EdD

The Influence of Joint Training in Learning Disability Nursing and Social Work on the Professional Identity, Skills and Working Practices of Graduates.

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ABSTRACT

The focus of this thesis is on the experiences and perceptions of practitioners who have undertaken a joint qualification in learning disability nursing and social work. Over the last 18 years, a small number of universities in England have gained approval to integrate two separate professional trainings into one programme of learning. Successful graduates have been awarded qualifications for both professions.

The thesis aims to contribute to understanding of the influence of this training on practitioners who have undertaken it, by exploring practitioners' perspectives on their professional identity, their use of the skills of nursing and social work and their working practices.

The study was carried out at a time of broad consensus among policy makers and professionals that inter-professional education can improve collaboration in care. It is informed by research and theoretical perspectives regarding inter-professional education and its impact on professionalism and on practice. Conceptual frameworks are drawn from the work of Bernstein (2000) and others to position the concept of joint training in the literature and research relating to professionalism, professional socialisation and identity.

The research employed a flexible, qualitative design. The data sources comprised a postal survey of jointly qualified practitioners who had graduated from five universities and colleges in England, followed by semi-structured interviews with twenty-five graduates from those who had responded.

The study found that the practice of graduates was determined by traditional service boundaries and roles. Whilst graduates' training had challenged singular professionalism in the field of learning disability, the duality and breadth of their skills were not recognised in practice. The study suggests that their professional identity is complex and socially constructed but is influenced by both disciplines. Its major contribution is to develop knowledge about dual professionalism and the implications for practitioners who occupy a new conceptual space between two professions and two discourses.

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I confirm that the work presented in this thesis is my own work. The thesis is 47,904 words in length, excluding the integrating statement, references, appendices and acknowledgements.

.....Dave Sims

LIST OF ABBREVIATIONS

BEI	British Educational Index
CAMH	Child and Adolescent Mental Health
CSS	Certificate in Social Service
CCETSW	Central Council for Education and Training in Social Work
CINAHL	Cumulative Index to Nursing and Allied Health Literature
DipSW	Diploma in Social Work
ENB	English National Board for Nursing, Midwifery and Health Visiting
GNC	General Nursing Council
GSCC	General Social Care Council
NHS	National Health Service
NMC	Nursing and Midwifery Council
PCT	Primary Care Trust
RLDN	Registered Learning Disability Nurse
RNMH	Registered Nurse Mental Handicap
SSD	Social Services Department
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

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INTEGRATING STATEMENT

> 'a defining feature of the professional doctorate is its focus on professional life and work, and an encouragement for participants to enhance their professional work through undertaking doctoral level study which privileges professional knowledge'
>
> (Scott et al, 2004, p. 36)

I believe the above quotation summarises my experience of doctoral studies at the Institute of Education over the past five years. The following statement aims to highlight the ways in which the EdD programme has contributed to my professional development and knowledge.

Professional Background

I began the EdD programme in 2001 and my doctoral studies have been continuous since that time. My decision to undertake the EdD programme was influenced by a period of nearly eight years of employment in the Faculty of Health at South Bank University. During this time I was programme leader for a degree programme in learning disability nursing and social work and subsequently became a Head of Division, with responsibility for social work, learning disability and community nursing programmes. By the time of my application to the programme I had gained a sound knowledge of the practical implications of implementing Higher Education programmes for professional education and had a good understanding of the interprofessional challenges and dynamics of working in a multidisciplinary faculty. I hoped that studying for a doctorate would enhance my professional knowledge and give me a greater understanding of the theory that could explain the practice of professional education and of the methodology with which to explore and enhance that practice further. Involvement in small scale research projects at the University had developed my interest in research but I was conscious of the need to develop my capacity to further understand, critique and carry out research.

I also embarked on the doctorate for self-enhancement. This was at a time when my Head of Division role appeared to be becoming increasingly *managerial* (PRP was being introduced and management training a requirement) and my original reasons

for working in Higher Education (seeking creative fulfilment and an extension of learning through teaching) were increasingly under question. Although I did not fully realise it at the time, the EdD would give me a valuable opportunity for reflection on the broader professional issues at the heart of my own individual circumstances. The trajectory of my studies took an unexpected turn early on in the programme, when I took up a new post as Professional Lead for Social Work at the University of Greenwich.

Professional and Academic Learning

The expectation to comment on these two aspects raises the question as to whether it is possible to separate them when undertaking a professional doctorate. Reflecting on ideas discussed by Scott et al (2004), my experience of undertaking the doctorate has been a negotiation between different communities of practice and I believe that this has extended my critical knowledge. There have been three phases in my development, which I believe link to the three main phases of the EdD: the taught programme, the Institution Focussed Study and the Thesis. In this section I will reflect on each phase in turn and discuss the links between them.

There were different aspects to my development as I progressed through the *four taught modules*. The first of these was the powerful impact of studying with a group of fellow students from different parts of the world. My learning from the group discussions was significant and I believe my critical knowledge was meaningfully extended through this experience. Critical discussion about European 'development agendas' carried into other parts of the world, reflection on the outcomes of colonisation, and discussion of inequalities and power relationships in and between different cultures all gave me insight into global issues where previously my critiques had been mainly national, but not international.

The second aspect of development arising from the taught programme related to professionalism and my critical understanding of it. The early analysis and discussion of the concept of managerialism enabled me to put into a more theoretical context earlier learning in practice. Having worked in both the NHS and Social Services I had experienced first hand the introduction of NHS trusts and care management following the community care guidance and legislation in the late 1980s. Whilst my teaching

about these had adopted a critical edge, the *Foundations in Professionalism* module enabled me to reflect upon the concepts of professional identity and deprofessionalisation as they applied not to *what* I was teaching but to *who* I was teaching. Jointly trained practitioners in learning disability nursing and social work were emerging into practice with uncertain identities at a time of major change. This module gave me new theoretical insight about professionalism as it applied to these practitioners.

The third significant aspect of learning from the taught modules related to research methodology. When I began the doctorate I had only experienced a small amount of research methods teaching in my earlier development, and that which I had learned I had little opportunity to apply. Both Methods of Enquiry (MOE) modules were very important to my understanding of research paradigms and their implications for justifying research methodology. Both gave the opportunity for critical reading of research and learning about the practical and theoretical issues to consider when preparing to undertake a study. For example, a lecture and group exercise on questionnaire design followed by the use of the questionnaire with students from a community college enabled me to learn about the importance of straightforward wording. This was subsequently helpful when designing questionnaires for use in a focus group for the MOE2 assessment, and for both the Institution Focused Study (IFS) and thesis.

The IFS gave me the opportunity to apply the practical learning about research methods to an area of my own professional practice. The focus of the study was to evaluate the impact of a post qualifying social work programme (which I led) on the practice of students several months after they had completed it. This gave me experience in the steps of developing the full cycle of a study and in using a flexible design (survey followed by interviews), which would then also be used for the thesis. I believe the IFS developed my confidence in carrying out research interviews and in the process of data analysis, which I was relatively new to.

Work on the thesis has further extended the critical knowledge acquired during the taught elements of the programme and the application of research methods developed during the Institution Focused Study. In exploring a topic which has professional

identity at its heart, it has brought together aspects of my doctoral studies which began with analysis of professionalism five years ago. The issues of professional autonomy, status and identity have continued, during the course of my studies, to remain part of a contemporary debate in which different professions are renegotiating or reshaping their professionalism. My own discipline of social work has emerged strengthened through the reforms introduced in 2002 following the establishment of the General Social Care Council, reforms which have led to a new degree in social work and to professional registration. My work over the past four years has been to develop and implement this new degree and this has been significantly influenced by my doctoral studies. Two examples of the influence have been the introduction at level two of an Appraisal of Evidence for Social Work Practice course which I designed and now teach (which includes research methods) and the development of shared learning with nurses also studying at my university.

Professional Development and Knowledge

There have been four ways in which the EdD programme has facilitated my development, in addition to those specifically relating to the taught elements of the programme. The first of these has been the opportunity to study at a centre of excellence and to use the resources available to doctoral students. The extensive library provision has developed the breadth of my reading and my ability to use electronic databases and online journals to access relevant materials. Learning to use SPSS and Nvivo have both contributed to confidence building in data analysis and presentation, demonstrated in both the IFS and the Thesis.

A second impetus of development relates to research presentations and publications. Although I had carried out a small number of presentations and published some evaluative articles and chapters before commencing the doctorate, these did not strongly relate to *research.* During my doctoral studies I have undertaken presentations in respect of both the IFS and the thesis, including one at the Doctoral School conference in 2006. I have also published two journal articles. One article was published in *Educate,* based on work undertaken for the International module. Recently, work on the thesis led to a publication in *Community Care.* I aim to build on the work of the thesis to write further articles to disseminate the findings.

The third way in which my development has been facilitated is in respect of teaching in my own field of social work. Reading for both the IFS and the thesis has greatly developed my knowledge about the professional context of social work, which has been subject to rapid change. This knowledge has been shared with the prequalifying and postqualifying students I teach at my university, through sessions regarding topics such as professional socialisation and contemporary postmodern social work.

The fourth area of development significant to my experience of undertaking the EdD has been the international dimension. When I became a student at the Institute in 2001 I originally enrolled on the EdD *(International)* programme. I had hoped to capitalise on my knowledge of Spain and France and two modern languages to explore aspects of international social work. Undertaking the Specialist Course in International Education enabled me to begin to do this and I learned a great deal from preparation for the assignment, which focused on a comparison between social work education developments in England and Spain.

However, as my studies progressed and a change of job brought me into substantial involvement with post qualifying social work education for the first time, I decided to focus both the IFS and the thesis on national rather than international issues. My particular interest in the impact of joint training in learning disability nursing and social work was rekindled by my doctoral studies and I therefore chose this topic area for my thesis which began in 2004.

A Personal Journey

Undertaking the doctorate has been a personal journey towards the realisation that research has a major part to play in the successful implementation of education and that education has a major part to play in the successful implementation of change. It has made me even more aware than before of the vital role Higher Education has to play in the development of health and social care practitioners and of the vicarious impact on practice that educators in universities can have. Their role involves a critical dimension which can challenge the conservative impulse of much policy making. Doctoral studies have, I believe, sharpened my critical thinking and given me a stronger basis for my own professional practice.

CHAPTER ONE

Introduction

1.0 The Purpose of the Research

The purpose of this research was to investigate the influence of joint training in learning disability nursing and social work on the professional identity, skills and working practices of graduates who qualified from universities between 1994 and 2004. A flexible research design was adopted in order to explore the unique perspectives of these jointly qualified practitioners. The study undertaken was exploratory and investigated a subject in which almost no research has been carried out. Its contribution to knowledge has been to illuminate how inter-professional education (IPE) can influence professional identity and working practices and create a new 'professional space' characterised by duality rather than singularity. The study identifies ways in which dual professional socialisation creates both benefits and tensions for graduates in managing a new identity in health and social care services. In so doing, it reveals the close interrelationship between professional education, practice and identity, a relationship which can be paradoxical when innovation in professional education challenges established professional practice.

This first chapter aims to contextualise the study undertaken and begins by exploring some of the assumptions about joint training. This is followed by a section which describes the current context of inter-professional education and collaborative working, and identifies theoretical perspectives which situate the study within a changing professionalism. The next two sections introduce the background to joint training and identify the research question. In the final section details of the overall structure of the thesis are given.

My interest in the topic chosen for this thesis developed from my involvement in joint training over a period of eight years. I worked as programme leader of a joint programme at a university in South East England from 1994 to 1998 and continued my involvement with it for a further four years. This experience acquainted me fully

with some of the challenges of delivering a joint training programme and brought me into contact with other such programmes in England.

Prior to working in Higher Education, I had worked in learning disability services in both an NHS Trust and subsequently a Social Services Department. This gave me the benefit of understanding the two cultures which are often at the heart of discussions about health and social care and which frame the experiences of students on these programmes.

In my work coordinating joint training I became aware of the tensions which existed in a programme that was jointly validated by two professional bodies and therefore subject to double scrutiny. I was also interested in how the students perceived and managed their professional identity once qualified, given that they were being socialised into two professional groups simultaneously. In a post hoc evaluation carried out with the first two qualifying cohorts from this programme, respondents believed they adopted an holistic approach, worked effectively with the multidisciplinary team and held a wide knowledge base (Davis et al, 1999). In further evaluation activity however, graduates reported a lack of opportunities to use all their skills, suggesting tensions arising from the training (South Bank University, 1999).

The forty-seven respondents involved in this study were graduates from five joint programmes in England. Their responses to a postal survey led on to twenty-five of them taking part in semi-structured interviews. Researching their perceptions sought to establish the extent to which these 'hybrid' practitioners (Manthorpe et al, 2004, p 98) were influenced by their training.

The only national audit of joint training programmes, carried out in 1999, found that 136 jointly trained graduates had qualified from those then operational (Webber and Taylor, 2000). Since then seven further cohorts have qualified from each university, significantly increasing the number of jointly trained graduates in practice. Support for this model of training has related to its inter-professional nature and the belief that it can produce a practitioner better equipped to work in learning disability services, as these have become increasingly integrated and require a collaborative approach to service delivery.

There are, however, untested assumptions behind this belief, which my research explored through the perspectives and experiences of graduates. In the audit referred to (ibid, 2000), programme leaders and their agency partners were asked what they thought the benefits of joint training were. Amongst those identified were:

- the promotion of multi-agency working and shared professional understanding
- the integration of health and social care practice including the joint practitioner's ability to undertake holistic assessments
- professionals who were able to take forward the government agenda of partnership and joint working
- skills in working across the professions

The espoused benefits of the training are also expressed in the rationales given by employers who have supported it and universities which have delivered it. In an early evaluation carried out by Brown (1994), employers found the training offered a wider range of skills and approaches than single courses. Additionally, practitioners were perceived as able to provide a bridge between health and social care agencies.

Educators have also articulated the assumed benefits of the training. In the research carried out by Manthorpe et al (2004, p. 95) a lecturer on a joint training programme stated that

> 'it equips practitioners to work across all fields..... these people will be the practitioners for the future'.

Etchells et al (1999, p. 415) in their study of students on a joint training programme said of the objective of the training:

> 'Our joint programme attempts to prepare students to work holistically; to put aside any contradictions in roles, responsibilities and attitudes in order to provide a more effective and more respectful service to users'

These aspirations suggest an important paradigm shift in both educational and professional terms, but contradictions in roles may not be easy to resolve for practitioners who have been trained in two disciplines simultaneously. Barrett and

Keeping (2005) observe that different professional groups have their own cultures, encompassing a particular set of beliefs, values and norms. This implies tensions for these practitioners once they are qualified. Despite this, joint training is an innovation that has endured for almost two decades without systematic evaluation, and a search of the literature revealed the absence of an evidence base about the outcomes of the training. There is, however, an *ethical imperative* for evaluation because the merging of disciplines could have an impact on skill levels or lead to role confusion.

1.1 The Contemporary Context: Interprofessional Education, Collaborative Working and Professionalism

At the heart of the benefits identified above are collaborative working and effective membership of the multidisciplinary team, a term which describes many different types of collaborative working arrangements (Ovretveit et al, 1997). Meads and Ashcroft (2005) assert that collaboration involves different degrees of power and influence and is more than just teamwork. Many authors contend that collaborative working can be developed through inter-professional education (IPE).

According to Low and Weinstein (2000), successful collaboration between professionals is increasingly recognised as a necessary part of effective service delivery. Whilst developing 'joined up working' has been a key aspect of health and social policy over the last ten years, the promotion of joint strategy, planning and working together has been espoused for much longer than that. Most recently, policy has focused on integrating services as a way of achieving these objectives. The development of health and social care trusts following the Health Act 1999 provided a new rationale for the development of workers whose skills cross traditional professional boundaries. As a special form of IPE (fully integrating the two disciplines) joint training therefore has contemporary relevance and importance. It aspires to develop an 'integrated' professional.

The emergence of care trusts means that collaborative working arrangements are taking on new organisational forms and services need professionals who are competent to collaborate at a range of levels. The complexity of the collaborative task is indicated by Barr (1998, p. 184), who defines collaborative competency as

> 'Dimensions of competence which every profession needs to collaborate within its own ranks, with other professions, with non-professionals, within organisations, between organisations, with patients and their carers, with volunteers and with community groups'

Interprofessional education (IPE) has long been advocated as a logical 'common sense' means of developing collaborative practice. There is a significant body of literature and research which charts the development and nature of interprofessional education and this will be explored in chapter two. Pursuit of collaboration is also linked to the modernisation agenda (Meads and Ashcroft, 2005) and has implications for professional roles and identity. IPE brings greater scrutiny to professional roles, in some cases raising questions about which professional should carry out which particular tasks where this was previously prescribed. This debate is part of a larger one characterised by changes in thinking about what it means to be a professional. More integrated, collaborative ways of working impact on professional identities. As Meads and Ashcroft (2005, p. 3) assert:

> 'Being a professional today means becoming interprofessional'

Barr et al (2005) observe that IPE implies a shift in focus from learning what we do to learning what others do, as a way of responding to the new complexity at the heart of health and social care. In the disciplines at the centre of this study it has opened up professions to change and produced a contested area of practice. Joint training has called into question professional singularity, raising questions about professional identity and the role of education in shaping it.

Changing service provision increasingly involves a renegotiation of professional roles and responsibilities. Carrier and Kendall (1995) describe a difference between multi professional work and interprofessional work. The former allowed traditional forms of knowledge and authority to be maintained but established a willingness to collaborate across administrative boundaries. The latter, however

> 'implies a willingness to share and indeed give up claims to a specialised knowledge and authority, if the needs of the clients can be met more efficiently by other professional groups'
> (Carrier and Kendall, 1995, p. 10)

These authors assert that this will make the qualities of professional knowledge functional for the client rather than for the professional. Interprofessional education will, if successful, lead to a

> 'new form of interprofessional self-awareness'
> (Carrier and Kendall, 1995, p. 30)

Claims to a specialised knowledge and authority have traditionally been the indicators of professional identity and status. In chapter three the literature regarding professionalism and professional socialisation will be appraised for the contribution it can make to this study. This will draw on the important work of Bernstein (2000) whose theory of the development of academic and professional disciplines illuminates the way in which singular classifications can be destabilised by joint training, leading to a broader region of knowledge for professional practice. Joint training can be seen to frame the requirements for learning disability practice more holistically than before.

The contemporary importance attached to interprofessional working and to IPE suggests that the ability to work beyond the singularity of one's professional discipline is increasingly regarded as a defining characteristic of professionalism. Barr et al (2005) observe that IPE remodels the workforce. New identities and discourses can emerge from it. Elsewhere, Barr (2004) observes that change in healthcare is driven by a number of factors which include the demands of practice and rising public expectations. Education responds to this, but it is also dynamic. It

> 'also initiates, as a change agent in its own right'
> (Barr, 2004, p.vi)

If this is the case, then joint training has the potential to lead to the development of a new professional habitus (Bourdieu, 2000) in those who undertake it, as their professional persona is influenced by experiences and aspects of two discourses and they gain cultural capital from two different professional sources.

In recent years the study of professionalism has been characterised by critiques of professional status, behaviour and powers of self regulation. The position of

professionals has been called into question by the decline in deference and calls for greater accountability. Professionals are increasingly expected to be transparent about what they do and why and how they do it. In the case of doctors for example, it is said that their place is within a multidisciplinary team, where interprofessionalism can be more widely acknowledged (Royal College of Physicians, 2005).

Some authors refer to a *new professionalism* (Davies, 1996, Irvine, 1999, Watson and West, 2006). This may require the need to rethink professional tasks and identities in the face of greater public scrutiny, awareness and demands. It is my belief that the process of joint training is a part of a gradually changing professionalism. This study explored how graduates managed a professional identity for which there was no previous template, an identity which was both nurse and social worker and yet not fully either. The training created a new, undefined discourse and the data presented in chapters five and six shows that singular professional discourses could not fully explain the practice of these professionals.

Joint training is also an example of the way in which new roles can develop which sometimes cross or challenge traditional professional boundaries, bringing about uncertainty and a need to renegotiate activities and responsibilities in the field of practice. In the literature on professionalism, ambiguity is seen as part of a new and more complex working context in which practitioners of different disciplines share many of the same values and attributes.

1.2 The Development of Joint Training.

Gilbert (2005) asserts that collaboration in health and social care is not learned simply through attending courses. Learning effective collaboration

> 'requires both a personal transformation in view and a change in professional identity'
> (Gilbert, 2005, p. x)

Joint training was established with the idea of being transformative. The practitioners were not just expected to collaborate. It was supposed they would *embody* collaborative thinking and action.

The last two decades have seen a major change in the organisation of social work and nursing services for people with learning disabilities. As services have developed and integrated, the roles of professionals to support this service user group have come under scrutiny. Prior to joint training programmes, practitioners chose either learning disability nursing or social work, the latter being shorter and far less specialised than the former . The emergence of joint training created a different conception of professional practice for graduates, who were able to seek employment as either a learning disability nurse or a social worker once they were qualified. It challenged the professional boundaries between the two disciplines through its complete integration of two professional discourses.

The roots of joint training can be found in the 1970s, a decade of service change in the field of learning disability, during which community services increasingly replaced hospital provision. Major plans for hospital closure proposed in the White Paper Better Services for the Mentally Handicapped (DHSS, 1971) meant that the need for learning disability nurses had been called into question. Analysis of service and training needs led to movement towards the idea of a social worker as the main keyworker in the field, not a nurse. This shift in thinking was evidenced in the Briggs Report (DHSS, 1972), which proposed that there should be a new professional worker to support people with learning disabilities, based on a social work model.

In 1979 the Jay Report (DHSS, 1979) recommended the discontinuation of learning disability nursing and its replacement by the Certificate of Social Service (CSS) social work qualification. This proposal was in due course rejected by government. The 1970s had, however, represented a decade of uncertainty about the future of learning disability nursing (Mathias and Thompson, 1992).

During this period of uncertainty the seeds were sewn for more cooperation between the learning disability nursing and social work professions, which were seen to share similar aims and goals in their work with people with learning disabilities. Whilst the two professions continued to compete to be the experts in learning disability services (Thompson, 2003), the similarities of roles had been recognised. This led to collaboration between the General Nursing Council (GNC) and the Central Council for Education and Training in Social Work (CCETSW) and to new training proposals.

Whilst the existing RNMH (Registered Nurse Mental Handicap) qualification continued to be the basis for nurse training, the syllabus developed 'social' characteristics and became more community oriented. The narrowing gap between learning disability nursing and social work was indicated by the fact that in their review of the impact of this syllabus, Walton and Brown (1989) recommended greater collaboration between nurses and social workers, particularly in practice learning.

Subsequent cooperation between CCETSW and the GNC during the 1980s led to the decision to pilot two jointly validated courses from which students would simultaneously qualify as a social worker and a learning disability nurse (Brown and Shaw, 1989). The underpinning rationale for these joint qualifying training courses was the belief that there was overlap in the interests, function and competence of nurses and social workers (Mathias and Thompson, 1992). Additionally, it was perceived that there was now an extended domain of knowledge and practice which applied to the health and social care of people with learning disabilities:

> 'the essence of our experience in the eighties is that, whilst patterns of competence may vary, they are all part of the one domain underpinned by the same knowledge and understanding of the client group. It is possible to hold commonality and diversity within a single framework across caring and remedial professions'
> (Mathias and Thompson, 1992, p. 240)

The first two joint qualifying training courses which began in 1988 were both in the south of England, one in Kent and one in Essex. Both were '2 + 1' programmes, comprising the two year Certificate in Social Service programme (CSS) followed by a third year to meet the requirements of the RNMH qualification. They were both associated with the running-down and closure of hospitals for people with learning disabilities (Brown, 1994). A key driver for these initiatives was the resettlement of people into the community.

During the 1990s six further 'joint training' programmes developed in universities in England. These programmes were based on integrating the professional requirements of the Diploma in Social Work (which was introduced in 1989 as the new national training for social work) and the newly named RLDN (Registered Learning Disability

Nurse) qualification. One of these six programmes closed during the late nineties as a result of changes in local commissioning arrangements. The five remaining programmes continue in operation, although one has recently ceased its intake of students due to doubts expressed by its NHS commissioners about the career destinations of students, many of whom have not taken up posts in nursing.

Joint Training programmes are commissioned through NHS Workforce Development Confederations/Regional Health Authorities and student places are therefore funded by the NHS with some funding available from the GSCC to support placements and service user involvement. They have, however, clearly developed out of the nursing specialism. There is no learning disability specialism in social work training.

Programmes last for three years and are offered at either DipHE or Degree level. Their distinctive features are:

- they are the outcome of local collaboration between representatives of nursing and social work services and education providers
- they are approved by both the Nursing and Midwifery Council (NMC) and the General Social Care Council (GSCC), normally through conjoint validation
- students have access to placements in the NHS, Social Services and the voluntary and independent sector
- shared learning takes place with students from the other branches of nursing and in some cases with student social workers who are following a single qualification route in the same university
- students are taught at university and supervised on work placements by both nursing and social work professionals during their programme
- students are normally assessed against a framework of learning outcomes which integrates the professional requirements of the two disciplines
- graduates qualify with fully recognised, separate professional awards in both learning disability nursing and social work, meaning that they can join both the NMC and GSCC professional registers and take up employment in either field

- as well as these professional qualifications they are awarded an academic qualification by their university/higher education institution at either Degree or DipHE level.

An analysis of current programme handbooks/course documents from two different universities as well as the very first handbook from one of these programmes (written in 1992) suggests common and continuing themes. Each of these universities state that programmes seek to develop practitioners with skills in critical analysis and reflection who have an understanding of the role of both the learning disability nurse and social worker. Additionally the aim is that these practitioners will be flexible and adaptable to change. These different aims interconnect, as illustrated by one programme's aim to

> 'enable students to think critically, appreciate the contested nature of nursing and social work theory and to respond appropriately, flexibly and creatively to change, uncertainty and ambiguity'
> (Definitive Course Document, University A, 2003, p. 7)

1.3 The Research Question

The central argument of this thesis is that the bringing together of two professional trainings into one programme of learning creates a new dynamic site for professional and interprofessional development. How the practitioners engage in and relate to their practice can help to explain how they integrate identities to 'become themselves'. Their development of critical attitudes and dispositions may be an expression of the culturally and historically constituted values of a new field (Webb et al, 2002). The professional socialisation of graduates in this study was complex because it was situated where two professional disciplines had agreed to meet for the purpose of promoting service change.

As will be discussed in chapter two, there is an emerging consensus that a key aspect of shared professionalism is collaborative practice. In this regard joint training reflects national policy towards an inter-professional approach to the education of practitioners in health and social care. Joint training is also, however, an example of how professional education can re-frame professional discourse and begin to re-classify two singular disciplines into one region of knowledge. In this thesis I will

argue that the resulting practitioner occupies a new space between two professional discourses, an expansive space redolent of the complexity and uncertainty which characterise contemporary professionalism.

In the process of working interprofessionally, roles can begin to blur, as tasks traditionally held by one discipline can be carried out by another. Hall and Weaver (2001, p. 873) believe that role blurring is necessary for the functioning of an interdisciplinary team, but that this brings with it

> 'much resistance and confusion associated with redefining roles'.

Members of the team must be prepared to leave the safety of their respective disciplines to

> 'embark on the relatively uncharted course of interdisciplinary work' (Hall and Weaver, 2001, p. 870).

The metaphor of an *uncharted course* is very appropriate for the subject of this thesis, which explores the following major question:

What is the influence of joint training on the professional identity, skills and working practices of graduates?

This is broken down into the following sub-questions:

- How do jointly trained graduates construct their professional identity?
- What are graduates' perspectives on using the skills of nursing and social work in their practice?
- What are graduates' reflections on the influence of joint training on practice?

1.4 Structure of the Thesis

Following this introductory chapter, the literature from the fields of interprofessional education and professionalism is explored in chapters two and three respectively. In chapter four the research methodology is presented and explained, giving a rationale for choice of research design. This is followed by two chapters presenting the

principal data collected during the research, chapter five focusing on the results of the survey and chapter six concentrating on the data from the interviews. In chapter seven there is a discussion of the findings, relating these back to the ideas in the literature. Finally, I will conclude the thesis in chapter eight by setting out a theoretical position on the influence of joint training on the professional identity, skills and working practices of graduates.

CHAPTER TWO

Interprofessional Education

2.0 Introduction

This chapter examines the background to and rationale for the development of IPE, aiming to place joint training within this wider educational context. Global and national factors which have influenced its development will be explored and evidence of the aims and perceived benefits of IPE will be analysed with reference to some of the practitioner attributes it claims to develop. The evidence base about the impact of IPE will be examined, including examples of studies involving shared learning between nurses and social workers. Links from the literature to joint training will be highlighted.

I will argue that the development of joint training in learning disability nursing and social work is an example of a collaborative movement towards improved practice through interprofessional education (IPE). Joint training is of significant interest because it has ramifications beyond professions simply learning and working together more successfully. It is a qualitatively different species of inter-professional development because it merges two disciplines. Students on joint training programmes engage in both *interprofessional* learning as social work students and *intraprofessional* learning as nursing students. The skills and the identity of graduates in this study were significantly influenced by this.

2.1 Defining terms. Why Interprofessional Education?

Leathard (1994) acknowledges the vast vocabulary of interlocking and overlapping terms used to describe activities that are interprofessional in nature. She categorises these as concept-based, process-based or agency-based terminology. Hammick (1998) also notes the level of complexity associated with terms used by those engaging in discussion about IPE.

Barr (2002) identifies two key terms applied by the Centre for the Advancement of Interprofessional Education. These are *multiprofessional education* and *interprofessional education.* The former is described as:

> 'Occasions when two or more professions learn side by side for whatever reason'

and the latter:

> 'Occasions when two or more professions learn from and about each other to improve collaboration and the quality of care'
> (Barr, 2002, p. 6)

The second of these definitions indicates that the aim of interprofessional education is to change or develop practice. This is put simply by Hammick (2000, p. 461) as

> 'learning together to work together'.

Low and Weinstein (2000) observe that shared learning can only take place when individuals or professional groups are willing not only to share their knowledge and expertise but allow others to use these. This suggests that the distribution of skills can be changed through IPE. It is part of a *collaborative project* for practice not just a new form of education.

Interprofessional learning 'from and about each other' implies a more active engagement than multiprofessional learning 'side by side', and the literature reveals a debate about how and when IPE should be carried out to be most effective. There is a recognised need for indicators about what type of IPE works, for which learners and in which situations. Interprofessional pedagogy is, however, a developing one (D'Amour and Oandasan, 2005) and the current lack of evidence of its effectiveness should not be seen as evidence of its ineffectiveness (Hammick, 2000). The same premise arguably applies to joint training.

2.2 Global and National Factors Influencing the Development of IPE

Wood (2001) suggests that the new, more complex reality of working practice in the healthcare professions, including an ageing population and an emphasis on managing long term chronic illness, has provided the major stimulus for interprofessional education. This complexity has a *global* dimension, reflected in publications by the World Health Organisation (WHO). A number of authors cite the influence of the WHO on the development of IPE. It has, for example, identified failings in the preparation of medical students to work in healthcare teams (Cable, 2002) and identified the need for a more holistic approach to welfare (Mandy et al 2004). Tunstall-Pedoe et al (2003) acknowledge the importance of *Learning Together to Work Together for Health*, the 1998 WHO publication which advocated multiprofessional education. Sully (2002) refers to a recent WHO report on global injury prevention which continues to reflect the importance of IPE.

On a national level, Miller et al (2001) observe that stakeholders in multiprofessional work and education have also been influenced by national reorganisation of both health care and higher education, changes in professional roles, developments in treatments and changing needs of populations. They suggest there can be different motives for espousing IPE. For example, for the NHS this is the emphasis on continuity of care. For Higher Education it is the aim for more flexible education to widen participation. As we saw in chapter one, the genesis of joint training was rooted in service change.

Growing emphasis on the capacity for teamwork is a feature of the professional context in which workers from different disciplines now find themselves (Ovretveit et al, 1997). In the past few years the NHS has sought to establish teamworking across professional and organisational boundaries and maximise the contribution of staff to patient care, highlighting their interlocking roles (DH, 2000). With the widespread emergence of multidisciplinary teams, tasks are beginning to be redistributed within and between professions, with overlapping skills and responsibilities requiring a renegotiation of activities:

> 'The changes in the health services over the last ten years have stimulated reassessments and re-evaluations of professional roles and core values. They have also led to a growing emphasis upon an improved capacity for teamwork.

> Those trends can be expected to increase, as tasks are redistributed within and between professions, and overlapping skills and responsibilities are identified and re-assigned, depending on patient and client need'
> (UKCC, 1999, p.15).

Barr et al (2005) note that IPE can be a means to generate a more flexible workforce, where a practitioner from one profession could substitute for another. The aim of giving patients a more focussed and efficient service has influenced and led to a reduction of the number of different health professionals in contact with patients (Miller et al, 2001).

There is some evidence in the field of learning disability that stakeholders may value one worker with all the skills rather than exposure to a range of different disciplines. In 1999 a report was commissioned by the NHS educational purchasing consortia for Avon, Gloucestershire, Bath and North Wiltshire about what kind of practitioner was needed for the learning disability field. It stated:

> 'One of the responses to the gaps in care created by boundary issues was the development of a practitioner who could operate across health and social care, and take forward the joint working agenda. This was viewed positively by the majority of research participants, using or working in the statutory services. For carers this was based largely upon the need to see lesser numbers of professionals'
> (University of Portsmouth, 1999, p. 27)

A range of explanations are given in the literature concerning the national policy background to the need for improved interprofessional working. Of key importance was the shift from institutional to community-based care over the last 30 years. Closure of long stay mental health and learning disability hospitals during the 1960s and 1970s (triggered by the 1959 Mental Health Act and the 1971 White Paper *Better Services for the Mentally Handicapped* respectively) established a major challenge for the delivery of community based services, where different professionals contributing to client care found themselves based in different locations and therefore unlikely to have regular contact.

During the 1970s and 1980s the principle of 'care in the community' developed but attempts by government to bring about better collaboration between the NHS and

Social Services Departments faltered. In 1989, the White Paper *Caring for People* (DH, 1989) identified collaboration between the NHS and Social Services as essential for the success of community care, but it wasn't until a change in government that partnership working began to dominate as an element of the 'third way' (Low and Weinstein, 2000).

The Labour government in 1997 began to signal major policy developments which focussed yet again on collaborative working. Quinney (2006) notes that one of the aims of the New Labour modernisation agenda was to generate 'joined up' services. Two modernising White Papers heralded a future of collaboration. *The New NHS. Modern. Dependable* (DH, 1997) proposed the development of Primary Care Trusts on whose boards Social Services would be important stakeholders. *Modernising Social Services* (DH, 1998a) announced reforms in social care and emphasised stronger partnerships with health. A parallel publication *Partnerships in Action* (DH, 1998b) proposed future plans for health and social care funding arrangements, opening up the possibilities of pooled funding and integrated provision. These plans were activated through the Health Act 1999, which, as noted in chapter one, paved the way for the development of care trusts, which were given legal status through the Health and Social Care Act 2001. These combine the joint resources of the NHS and Social Services Departments. These trusts were seen as a strategy for building services around patients' and service users' needs:

> 'They will create a stable organisational framework for long-term service and organisational continuity and the kind of joined-up personal contact needed to improve services'
> (Department of Health, 2001a, p. 15)

Glen (2004) attributes the new emphasis placed on IPE to the pace of change in healthcare policy since 1997, observing that the *NHS Plan*, published in 2000, sought to set

> 'the patient at the centre of the care approach.... building effective inter-professional team working.... enabling care to be provided by the staff member with the most appropriate skills regardless of role or title'.
> (Glen, 2004, p. 2)

This vision represents a radical shift from the profession oriented service which it is proposing to move away from. It challenges professionals' monopoly over specific skills and suggests a new shared professionalism. The NHS Plan proposed a new common foundation programme of education across professions (Mandy et al, 2004).

Notably, the drive for IPE has also been strengthened by the frequent and often tragic failures in collaboration by professionals. Stanley and Manthorpe (2004), in their meta analysis of child care reviews and public enquiries from 1973 to 2001, demonstrate that issues of interprofessional collaboration, communication and coordination were significant and problematic in a large number of these. As a result of high profile reviews and enquiries, IPE in child protection is now commonplace, resulting from guidance in government reports such as Working Together to Safeguard Children (DH, 1999) and recommendations in child abuse reports such as the Cleveland Enquiry (Gill and Ling, 1995).

Failures in child protection have been well documented. Successive governments have attempted to respond to these failings by promoting interprofessional education to improve communication and decision making. Barr et al (2005) recognise poor communication as a key contributing factor to problems in collaboration.

As a response to issues raised by the Climbie case, there has been an intensification of policy and procedure relating to collaboration. The publication of the Green Paper *Every Child Matters* (Department for Education and Skills, 2003) challenged services to improve collaboration to safeguard and protect children, proposing the integration of Social Services for Children and Families with Education Departments. The development of locally based inter-professional procedures (eg. the London Child Protection Procedures) has sought to bring consistency into collaboration within regions. The publication of the National Service Framework for Children (DH, 2004) has further emphasised collaboration between services.

2.3 The Collaborative Movement

Whittington (2003a) asserts that there is now a broad consensus across the social care spectrum that partnerships are essential between services and that it is skilled collaboration that can make these partnerships work. Echoing this, Cable (2002)

identifies one of the key challenges of modern healthcare, namely the creation of systems which can function in a seamless manner when faced with the complex problems of patients. Complexity is itself acknowledged as one of the major service challenges which puts practitioners under pressure and requires them to respond to problems which are sometimes beyond their education, experience or role (Barr et al, 2005).

Whittington (2003a, p. 27) describes collaboration and partnership as

> '*instruments of policy* chosen to achieve particular social and political goals, such as supporting independence of older people by seeking an effective blend of social and health care and thereby reducing waiting lists'.

Current policy driving the reorganisation of services into health and social care trusts assumes better client care and value for money as an outcome. Hammick (1998) observes that *patients* (as well as policy makers) also recognise the value of collaborative practice.

The search for an 'effective blend of health and social care' appears to lie at the heart of what Barr et al (1999) refer to as *the collaborative movement*. This seeks to:

> 'cultivate better relations between professions, respecting the identity of each while valuing and utilising differences'
> (Barr et al, 1999, p. 533)

Tunstall-Pedoe et al (2003) believe that teamwork is an important outcome of improved collaboration, resulting in better working together in more cohesive teams where there is good communication, respect, and an understanding of others' roles.

Cable (2002) asserts that at the heart of aspirations towards improved collaboration are not only a greater awareness and sensitivity to the needs of patients by professionals, but also the interaction between policy developments in health, education and practice. The integration of nurse training into universities in the 1990s created scope for educational collaboration in pre and post qualifying training. Further, developments in the education commissioning role of local NHS Workforce

Development Confederations aimed to strengthen the links between health, education and practice (DH, 2000).

Cable (2002) also observes that changes in healthcare demand a move from a position where professionals occupy discrete professional roles to one where integration is needed. The failure to integrate is seen as a problem and the removal or surmounting of 'barriers' set as the objective. A 'Berlin Wall' is said to exist between health and social services (DH, 1998a). 'Seamless care' is recommended (Weinstein, 1993). Competences for collaboration are identified which, if possessed by all professional practitioners, may improve working together (Barr, 2002). There is almost universal recognition in the literature of the need for practitioners and services to collaborate.

Barriers and boundaries are frequently cited in the literature as reasons for non collaboration in practice. Low and Weinstein (2000) identify professional socialisation and ideological differences as reasons for non collaboration, rooted in initial training:

> 'Professional roles and preparation for those roles often reinforce differences in professional values that underpin contrasting approaches to care. While each profession has to have its own sense of identity and values, these can become so entrenched that they create problems for working across professional boundaries. Much of the resistance to multi-professional education is due to the fear of dilution of professional role and loss of professional identity'.
> (Low and Weinstein, 2000, p. 214)

These authors believe that separate professional education gives rise to stereotypes. There is some evidence, however, that stereotypes exist before initial training, particularly where the parents of students are health care professionals (Tunstall-Pedoe et al, 2003). There is clearly a suggestion here that strong professional identities can be obstructive in effective care delivery. This may not be simply due to professional stereotyping, but also due to the singularity of perspective developed through professional socialisation and the status differences between professional groups. Bernstein (2000) provides an analysis of how knowledge structures are socially constructed to create disciplines referred to as 'singulars',

> 'whose creators have appropriated a space to give themselves a unique name, a specialised discrete discourse with its own intellectual field of text, practices, rules of entry, examinations and licences to practice'
> (Bernstein, 2000, p. 52)

It is this uniqueness and singularity that joint training appears to challenge through merging two discourses. In integrating two discourses joint training proposes a multi-skilled, collaborative practitioner. At the same time, however, this creates an unpredictable impact on professional identity.

The collaborative movement has resulted in revisions to professional training requirements which reflect the importance of IPE now attached to professional practitioner development. An emphasis on shared learning is now a significant feature of nursing and social work curricula. In 1994 the English National Board for Nursing, Midwifery and Health Visiting (ENB) and CCETSW agreed a joint strategy for shared learning (Miller et al, 2001). In 1996 they developed a policy on the conjoint approval of joint training programmes in learning disability nursing and social work (ENB, 1996a). The developments of the revised curriculum for Nursing (UKCC, 1999) and the new Degree in Social Work (DH, 2002) both sought to encourage shared learning during professional training. In 2002 a government grant was made available to establish *Creating an Interprofessional Workforce*, a programme which aimed to promote interprofessional learning and development through consultation and dissemination activities. It sought to capture the learning from a range of projects including common learning programmes for health professionals in universities. Initiatives such as these clearly aim to develop professionals' capacity to collaborate in practice but they also have other implications, including a shift to

> 'new concepts of professional identity and new relationships of professions to other professions'
> (Meads and Ashcroft, 2005, p. 27)

In chapter three the concept of professional identity will be further explored because identity change is at the heart of the joint training process. The graduates in this study had to manage the 'newness' of their professional identity.

2.4 The Rationale for IPE. Benefits to Practitioners and Services

Ewens et al (2000) state that effective interprofessional education aims to help professionals change their mode of thinking with regard to collaborative work and sustain this change in practice. Consequently, these authors judge that IPE:

> 'needs to help students explore their own roles, to learn from others and to be aware that collaborative work entails some loss of role'.
> (Ewens et al, 2000, p. 18)

In most interprofessional education the process involves bringing different professionals together to learn more about each others' roles, values and perspectives and as a consequence to work better together (Leathard, 1994). According to Hind et al (2003), this contact will help participants to discover similarities and also differences between each other which will change stereotypical attitudes. Hammick (1998) perceives that the value of IPE is in enhancing collaborative care by offering multiple perspectives on clinical issues. It is an educational means to a practical end.

Funnell (1995) identifies four expected outcomes from interprofessional shared learning which emerge from the literature. These are: the enhancement of understanding about the roles of other professionals, the promotion of future teamwork and cooperation between professional groups, the development of the learner's knowledge of particular subject areas and the development of practical skills.

Wood (2001) identifies broader and more personal benefits: an increased ability to share knowledge and skills, enhanced personal confidence and professional development, greater respect between the professions and the encouragement of reflective practice. Barr et al (1999) also include the cultivation of *respect* through IPE, as well as the modifying of reciprocal attitudes and perceptions and the exploration of ways in which collaboration can be made more real. Leaviss (2000) suggests that interprofessional learning can overcome barriers, increase trust, dispel stereotypes and improve interprofessional relationships.

In identifying factors which promote interprofessional working, Barrett and Keeping (2005) summarise some of the benefits to practitioners and practice relationships.

These include knowledge of professional roles, confidence, open and honest communication, trust and mutual respect, sharing of power, acknowledgement of uncertainty and a willingness to participate in collaboration.

Hammick (1998) observes that what will determine the success and continuation of IPE will be the patient's quality of care. Wilcock and Headrick (2000) suggest that the ultimate goal is to seek a closer link between health care delivery and professional education, bringing together the needs of patients and communities with those of learners. They identify four goals which can be achieved through IPE, leading to a more patient centred approach which:

- Seeks to understand and meet patients' needs
- Organises care as a system focused around that need
- Takes advantage of what teams of professionals can do when they work well together
- Improves constantly through the active efforts and innovative ideas of the health care team
  (Wilcock and Headrick, 2000, p. 111)

Barr et al (1999) suggest, however, that in any field of education it can be difficult to show a linear relationship between educational intervention and its outcome. Barrett et al (2003) assert that the effectiveness and impact of IPE are still relatively unknown, despite the prominence it has gained during the last decade. In a similar vein, Whittington (2003b) observes that evidence about the impact of collaboration and partnership in terms of improving practice has been slow to accumulate. Glen (2004b, p. 157) also acknowledges this lack of evidence but emphasises an *intuitive* value:

> 'The ability of health care professionals to work together collaboratively is critical to delivering patient centred care. The proposition that learning together may help people to work together more effectively is intuitively reasonable.'

This author is not alone in pointing to the need for a stronger evidence base to support claims about the effectiveness of IPE and to establish the impact of learning on professional practice and to evaluate longer term outcomes. She highlights the danger, however, that too much focus on the search for evidence could stifle attempts to experiment or innovate, without which no evidence will develop.

2.5 Interprofessional Education. Questions of Identity and Role

Joint training in learning disability nursing and social work is offered as pre-qualifying training. In respect of IPE generally, there are differences of view in the literature about when this should take place. Hammick (1998) distinguishes between *Type 1* and *Type 2* IPE. The former refers to undergraduate courses with mostly pre-qualification experience, the latter to courses for qualified, post-experience staff. Joint training is clearly Type 1 in this categorisation.

The debate in the literature about when IPE should happen relates back to the theme of professional identity and role. It can be summarised as follows: should a practitioner be certain of their own identity before laying it open to the challenges of role blurring, boundary crossing and possible role confusion? Or is it too late then because singular professional identity is so strong it impairs the ability to compromise and negotiate roles after initial qualification? Hall and Weaver (2001) assert that this debate is unresolved and they identify in their literature review evidence of support for both types of IPE and an absence of consensus about ideal timing. What is interesting about joint training is that it overrides this debate and attempts to 'ground' graduates in two disciplines simultaneously.

Two pieces of relatively similar research highlight the opposing positions regarding the best time to undertake IPE. In a study carried out by Kilminster et al (2004), researchers delivered three interprofessional workshops to 28 trainee doctors, student nurses and pre-registration pharmacists. All were well advanced in their initial training and most commented that they felt the timing was good because they had already developed a sense of their own professional identity and an understanding of the practice environment. Leaviss (2000) however, ran a two day multiprofessional course for doctors, nurses and allied health professionals in the final year of their training. She found that only two out of fifteen students reported more positive attitudes to other professionals. She concluded that IPE should be introduced earlier than the final year in order to have a real impact on changing attitudes, and recommended reinforcing this by prolonged positive exposure to other professions during training.

Hind et al (2003) observe that students' readiness to engage in IPE may be enhanced by a clearer notion of their own professional identity, as in the Kilminster study above. Mariano (cited in Hall and Weaver, 2001, p.869) suggests that the freedom to be interdisciplinary may only come with security in one's own discipline.

The concept of *role security* is seen by a number of writers as a prerequisite to successful shared learning. Carpenter (1995) observes that where this is lacking in the learner, shared learning may reinforce *insecurity*. Funnell (1995) observes that for IPE to be successful it is essential that it is perceived to be *relevant* by all its participants and if so this can have the effect of reducing professional isolation and problems of role ambiguity and insecurity. Perceptions of relevance may relate to the stage of professional development that the learner has reached.

Carlisle et al (2004) note that introducing IPE at post-registration level may be a solution where there is poor *existing* interprofessional teamwork caused by professional role boundaries and barriers, but they also observe that:

> 'this is a bit like shutting the door after the horse has bolted. It would be better to prevent these professional jealousies developing in the first place'
> (Carlisle et al, p. 545)

They suggest that starting IPE at the pre-registration stage could be a solution to interdisciplinary rivalry.

The concept of role security is important to this study. In an early, small scale evaluation of the training at one university it was revealed that no specific roles existed for jointly trained practitioners and that the experience of graduates had been to apply for either social work, care management or nursing posts and then seek to bring their skills to bear on the role they had taken up (South Bank University, 1999). This lack of fit between the training and practice raised questions about individuals' sense of security in role. In chapters five and six below, the data reveals some of the dilemmas faced by graduates who felt they were trained for a role that does not exist. It is possible that role security is stronger when professions are at their most insular. Indeed, Bernstein (2000) has suggested that insularity is one of the goals of singular education. Hammick (1998) draws on Bernstein's work to offer an analysis of

professional hegemony. She considers Bernstein's concepts of *classification* and *framing* to explore the ways in which knowledge is organised through rules shaping the social construction of pedagogic discourse. Early organisation of knowledge (in the nineteenth century) was in terms of singular discourses, the strength of their *classification* reflecting their unique definition, space, name and field for the production of knowledge. Bernstein observes there was a change in the twentieth century, towards the *regionalisation* of knowledge and regional discourses. Knowledge boundaries shifted to produce different ways of knowing. Professional education had traditionally been established for the production and reproduction of knowledge unique to a specialised group, and pedagogic practice had strongly *framed* professional discourses to

> 'effectively insulate one from the other and to establish clear boundaries between each professional category'
> (Hammick, 1998, p. 326).

Hammick argues that IPE introduces a pedagogy which aims to weaken the classification and framing of the unique knowledge of professions:

> 'The aim of IPE is to re-contextualise traditional and discrete bodies of professional knowledge into the knowledge of collaborative practice'
> (Hammick, 1998, p. 326).

This challenges the traditional aim of professional education, which has socialised recipients of it into a particular classification, as identified by Bernstein. This will be further discussed in the next chapter, as the connection between professional education, role identity and membership of a professional group has been a dominant theme in the literature on professionalism (Millerson, 1964) and has led to critiques of the power of professions to define their territory as powerful elites (Evetts, 2003).

Petrie (cited in Hall and Weaver, 2001, p. 869) refers to *idea dominance* as an important concept relating to IPE. This is the need for interdisciplinary teams to have a patient/client centred approach to their work, so that

> 'a clear and recognisable idea must serve as a focus for teamwork, rather than the traditional focus of each member's domain of care'
> (Hall and Weaver, 2001, p. 869)

With the patient/client at the centre, for the multidisciplinary team to succeed, each team member must perceive that he/she has achieved something through the collaboration. This refocuses the sense of purpose associated with individual's professional roles from their own singular performance to one of team performance.

In this way, the whole team's work is greater than the sum of the parts, thereby achieving a synergistic, holistic approach. *Idea dominance* can also explain the rationale for joint training – the principal idea is that the practitioner is combining two sets of skills and achieving 'more' for the service user through this. Something extra comes from their integration. An internalised synergy.

2.6 Evaluation of the Impact of Interprofessional Education

As identified earlier, there is a consensus in the literature about the paucity of research which *carries evaluation of IPE forward into practice* in order to provide evidence about the impact of IPE, although the literature is replete with examples of evaluation of IPE projects. One of the reasons for this may be that, as Low and Weinstein (2000) observe, IPE remains uncoordinated and fragmented and tends to involve short term or pilot schemes which can make systematic evaluation of outcomes elusive. Hammick (2000) notes that it is easier to obtain stronger evaluative evidence for outcomes such as the acquisition of knowledge than for actual changes in services. This was borne out by a recent systematic review reported by Barr et al (2005) which found that much research reported positive outcomes in respect of practitioner attitudes, knowledge and skills but impacts on practice were less visible in the literature.

Barr et al (1999) report that a search of the UK literature in 1995 found only 19 published evaluations of IPE, of which only a few were methodologically rigorous. In a subsequent Cochrane review reported by Zwarenstein et al (1999), it was found that no studies met the Cochrane criteria for systematic reviews, in so far as they provided rigorous quantitative research evidence on the effects of IPE (demonstrating a link between interprofessional education and improved practice in health and social care).

A similar conclusion was drawn by Reeves (2001) when engaged in a systematic review of inter-professional training and its impact on mental health care.

Hammick (2000) notes that there were difficulties encountered by Zwarenstein et al in using the Cochrane approach for a systematic review because of the requirement that studies reviewed must fit with specified methodological criteria *and* demonstrate impacts on client, patient or organisational outcomes. Some evaluations met one or the other of these requirements but none met both. She comments that it was too early in the development of IPE to use such strict inclusion criteria, partly because of the diversity of provision and also because of the lack of standardised evaluation.

Hammick (2000) reports that a parallel review was therefore initiated by the same research team, anticipating the lack of results yielded by the Cochrane review. This aimed to broaden the scope of review to include a wider range of evaluation methodologies and outcomes. It found that most IPE programmes were locally initiated and ad hoc, not yet being institutionalised into professional pre-registration or continuing education.

Details of this parallel review were reported by Freeth et al (2002). The research team carried out a systematic review of the international literature using a search strategy involving the Medline, CINAHL and BEI databases. 6477 abstracts were identified and 417 research papers were obtained which met the initial inclusion criteria requiring studies to both describe and evaluate interprofessional education. 217 studies were finally selected which fully met the inclusion criteria. These studies were found to be of variable quality, but 53 were classified as a higher quality subset evaluations which were analysed in more depth, using an analytical framework adapted from Kirkpatrick's four level model of evaluation (Thackwray, 1997). This model evaluates education in terms of learners' reaction to the educational experience, learning achieved in respect of acquisition of skills and knowledge, behavioural change (have the learners applied their learning to practice to do things differently?) and the impact on the community or organisation.

The higher quality studies were mainly 'before and after' and longitudinal studies, the majority of which were from the USA (78%) with 12% carried out in the UK. Year of

publication ranged from 1969 to 2001, although 59% had been published since 1995. 45% of these studies (n=24) reported changes in skill or knowledge relating to collaborative practice, including aspects such as improved knowledge of the nature of inter professional teamwork, better understanding of others' roles and improved teamwork skills. 25% of studies (n=13) indicated changes in behaviour including improved cooperation and communication. 48% of studies (n=25) reported changes in organisational practice following the IPE. Outcomes such as these therefore suggest some positive impacts of IPE on practitioner behaviour and knowledge. The authors concluded, however, that more evaluation was needed, including a smaller number of comprehensive evaluations of different types of IPE, evaluation of *innovation,* and *prospective* studies with lengthy follow-up periods.

The same research team subsequently carried out an updating of this review (Barr et al, 2005). 107 high quality studies were identified overall and from the results the team was able to identify three principal foci for interprofessional education. These were individual preparation for collaborative practice, the cultivation of collaborative group/teamwork and the improvement of services. The results provided evidence of positive outcomes against each of these, albeit with stronger evidence of change at the level of individual collaborative practice than that of service improvement.

2.7 Indicative Studies involving Nurses and/or Social Workers

During this review of the literature, which focussed principally on *educational and professional* journals and abstracts, it became apparent that significant interest has been shown in evaluation of IPE by academics involved in medical and nursing education in particular, where undergraduate interprofessional education has been encouraged, especially between doctors and nurses. There is much less evidence of research papers from a social work perspective and this may reflect the weaker classification and positioning of social work education as a professional discipline, given the relative under-resourcing of social work training until the recent introduction of the new Degree in Social Work. However, a number of small scale studies provide insights about possible impacts of IPE on nurses and social workers, especially in respect of professional stereotyping, communication and professional role or orientation.

In a programme of interprofessional shared learning involving final year students (16 undergraduate nurses and 23 medical students), a study by Carpenter (1995) revealed that overall attitudes to the other profession improved, with participants reporting increased understanding of the knowledge, skills, roles and duties of the other profession. The findings revealed that both medical students and student nurses initially held clear stereotypes of each other, both positive and negative, and that there was some improvement in the nurses' negative stereotypes of doctors, who had initially been perceived as arrogant, detached and poor communicators. There were no significant changes in the medical students' perceptions of nurses, which were not, however, particularly negative. The doctors were found to identify significantly more strongly with their profession than the nurses. The author suggests that the nurses' weaker professional identification *may* be attributed to the fact that nurses have a low status in society generally.

Barnes et al (2000) carried out an attitudinal study involving a one year programme of IPE for qualified social workers, community nurses, occupational therapists and other professionals involved in community mental health work. Data was collected from 71 students overall. In contrast to the above research, these authors reported that participants shared a common set of perceptions about the main mental health professions and the course did nothing to change these. It appeared that strongly held interprofessional stereotypes were reinforced through day to day contacts between professionals in the workplace.

Another example of undergraduate interprofessional education which has developed as IPE has become more popular in the UK is the *Common Foundation Programme*, whereby students from different professions undertake interprofessional learning early in their programmes. Tunstall-Pedoe et al (2003) evaluated one such programme which took place at the University of Kingston over the first term of students' learning and brought together medical students, student allied health professionals (AHPs) and undergraduate nurses. This study also reveals information about professional stereotyping. A total of 175 students responded by self completion survey both prior to the foundation programme and at the end of it. The findings demonstrated that many students arrived on the programme with strongly stereotyped views of other health care professionals. In this study, negative views of doctors held

by the AHP and nursing students had not diminished by the end of the common interprofessional foundation, but had become exaggerated.

In a further study, Ewens et al (2000) ran and evaluated a ten week course for community nurses and social workers, focussing on a family life cycle approach, with the aim of helping students develop a shared vision and understanding of client need in the context of the family and interprofessional working. Five social work and six community nursing students took part. The authors found that there were changes in ways of thinking over the period of the course, with students from the two disciplines developing shared perspectives. There was also improved interprofessional communication between the students in relation to client need.

Fowler et al (2000) carried out a study involving 24 social work students and 28 community nursing students (10 of whom were learning disability nursing students) in which all participants were exposed to two shared training sessions exploring professional roles and responsibilities. Students positively evaluated the opportunity to meet with other professionals, to discover new perspectives and to gain insights into the work of colleagues practising in other areas.

Finally, Russell and Hymans (1999) carried out an interprofessional learning project with social workers and community nurses in the United States, which revealed differences in the way each professional group approached a task. The aim was to expose students to the process of interprofessional collaboration. Students were asked to conduct a community assessment as one of 8 interdisciplinary teams (each comprising approximately 3 nursing and 5 social work students per team). A study of the process of working together revealed that the nurses tended to apply a more linear, task oriented approach to problem solving, using a predetermined protocol. The social workers, by contrast, appeared to have more experience in analysing alternative solutions to a community's problems, with a stronger long term orientation to their analysis. The groups found similarities in values between the two disciplines but differences in the way they approached their roles:

> 'Social Work students were perceived as more laid-back and easygoing by both student disciplines. Nursing students tended to be more task-oriented rather than

> relationship oriented. Nursing students were also perceived as strict time managers due to the other heavy clinical requirements in their nursing courses. Social Work students were socialised into balancing the completion of a task with maintaining effective team member relationships'.
> (Russell and Hymans, 1999, p. 259)

The authors concluded that the students learned about the *process* of interprofessional collaboration and developed a deeper understanding of the contributions members of each disciplines made to the completion of the project:

> 'Students were able to recognise the unique contributions of each profession, with nursing focusing on health status and social work focusing on social issues'.
> (Russell and Hymans, 1999, p. 259)

Through students' perceptions, this study draws to our attention an interesting difference between the professional *habitus* of the two disciplines involved, which appeared to be differentially task or process/relationship oriented. This raises interesting questions about my study, where the merging of two disciplines appeared to result in an holistic approach for some respondents, characterised by both a task *and* a relationship oriented approach to their practice.

2.8 Conclusion

This chapter has considered the relevance of the growing literature on interprofessional education to this study. Reflection on the background, aims and rationale for IPE locate the study in a developing field of evaluative research concerned with the influence of interprofessional education on practitioners and on practice. Both IPE and joint training programmes have arisen from a collaborative movement but to date there is limited evidence of their impact on practice. The aims and some of the espoused outcomes of IPE have been discussed. This will enable the findings of this study to be placed in their educational context, whilst acknowledging that joint training is both similar to but different from most interprofessional education developments.

CHAPTER THREE

Professionalism and Professional Identity

3.0 Introduction

The aim of this chapter is to position this study within the literature and research relating to professionalism, professional socialisation and identity. My research suggested that jointly trained practitioners stood somewhere between two professional discourses, both of which impacted on their identity. In this chapter theoretical perspectives will be explored to situate the development of joint training in the context of the *professional project* (Larson, 1977). Concepts of professional socialisation and identity will be related to the case of joint training to explore whether jointly trained practitioners can expect to achieve the distinct social identity which is said to emerge from professional training programmes (Freidson, 2001).

I will argue that joint training is an example of a transition towards a new professional grouping and represents a shifting of professional knowledge and territory and a 'resettling' of professional discourse. Additionally, it can be seen as an outcome of the trend towards professions becoming more accountable for and transparent about what they do. It is arguably only possible to merge the two trainings through a consensus that what they both have in common is a distinctly similar purpose, rationale and area for professional concern.

3.1 Professional Power and Change

In chapter one we saw how the the merging of disciplines within joint training threw into question the dominance of one profession (learning disability nursing) in service provision. Parkin (1995) describes professionalisation as a political process, with issues of power and control central to it. Loxley (1997) asserts that professions compete with each other for territory. Joint training brings tensions in respect of both the distribution of professional power and territory. The 'new' jointly trained professionals in this study observed some of the discomfort of change for other

professionals as they sought to understand a new kind of training. As Menzies Lyth suggests:

> 'Change is an excursion into the unknown. It implies a commitment to future events that are not entirely predictable and to their consequences, and inevitably provokes doubt and anxiety. Any significant change within a social system implies changes in existing social relationships and in social structure, which implies in turn a change in the operation of the social system as a defense system' (Menzies Lyth cited in du Gay et al, 2000, p.172)

Resistance is a characteristic of change. My own professional experience of delivering a joint programme meant encounters with resistant forces, sometimes reflected in negative or defensive attitudes of others towards joint training. This was sometimes the case with learning disability nurses, whose central position in the care of people with learning disabilities arguably laid their profession most open to risk from joint training. Social workers also questioned the value of the training, but had less to lose from a union of professions as there was no specialist qualification in learning disability social work. Katz (1969) notes the preoccupation associated with professional hegemony and change:

> 'few professionals talk as much about being professionals as those whose professional stature is in doubt'
> (Katz, 1969, p. 71)

Abbot and Meerabeau (1998) suggest that both nursing and social work are occupational groups that have striven to be recognised as professions. Larson (1977) places social work in the category of *organisation profession,* which has been

> 'generated mainly through the bureaucratic apparatus of the state.'
> (Larson, 1977, p. 79)

The beginnings of social work lay in the charity movement in the nineteenth century (Jones, 2002) but it has recently become increasingly subject to the influences of care management. Nursing, on the other hand, continues to be associated with the idea of vocation (Mackay, 1998) and whilst its origins are recognised as being diverse (as epitomised by its different branches), its historical development has been attributed to the needs of doctors for assistants as the profession of medicine emerged in the eighteenth and nineteenth centuries (Abbott and Wallace, 1998).

As will be seen in chapters five and six, my research data suggests that some graduates perceived a key difference between nursing and social work roles in the degree of professional autonomy that could be exercised, the former appearing to give a greater opportunity for this. A number of the interviewees who entered social work upon qualification equally aspired to do community nursing but were unable to find posts. Some who had chosen community nursing felt empowered by their choice of profession when comparing it with the care management roles that social workers had to carry out.

3.2 Professionalism –underpinning concepts and their relevance to Joint Training

The current context of professionalism is characterised by expansion, ambiguity and change. The numbers employed in professional occupations have increased substantially in the past two decades, the expansion being driven by such things as demographic changes, advances in technology, changes in social and environmental awareness, legislation and globalisation (Watkins, 1999). But where does the jointly trained practitioner fit within definitions of a profession and how does professionalisation occur?

Defining the concept of profession has itself been a preoccupation of many writers, who frequently use a 'trait' approach and suggest the traits it involves. According to Abbot and Meerabeau (1998) trait theories reveal that professions monopolise particular forms of expertise, seal themselves off behind boundaries characterised by entrance qualifications and extended training, and possess an ideology of public service and altruism. Eraut (1994), however, is critical of the trait approach to understanding professions, as traits can be arbitrary, difficult to prioritise in terms of importance and culturally specific. It is difficult to apply the trait approach to the jointly trained professional because the obvious question arises: which profession is the practitioner boundaried within?

In an earlier assignment (Sims, 2002a) it was noted that the 'trait' approach to defining professions (eg. discreet body of knowledge, tests of competence of members, code of practice) had lost some of its descriptive power as many traits apply to various occupational groups. Evetts (1999) asserts that the trait approach is

now regarded as an unhelpful diversion to understanding a complex phenomenon, and that it is now widely argued that occupations and professions share many features in common. Abbott and Meerabeau (1998) observe that recent literature is more concerned with the *professionalising strategies* of occupational groups as they seek to secure recognition as professions.

In the assignment referred to it was possible to identify a number of differences between learning disability nursing and social work (Sims, 2002a). A key difference related to the nature of the body of knowledge underpinning the two groupings. Social work was perceived as a *soft* knowledge domain, drawn mainly from the social sciences, whereas the foundations of nursing in the *hard* knowledge of biological science and positivistic research appeared to give it a greater prestige. Barnes et al (2000) observe that social workers are trained in the humanistic paradigm, whereas nurses are trained in the scientific one. This links to the *pecking order* of knowledge identified by Macdonald (1995) in respect of the professions, whereby some knowledge is perceived to have greater prestige and value than other.

Barnes et al (2000) consider the medical and social models to be important indicators of these different paradigms and how each discipline tends to see their practice. Davis and Sims (2003) noted that in a comparison of codes of practice nurses were expected to value patients' uniqueness irrespective of their diversity. Social workers on the other hand, were required to locate people in their collective and cultural context and take a proactive position in terms of rights and discrimination. This suggests a difference of emphasis in the two discourses.

Defining a profession, Freidson (2001, p.142) describes this as

> 'all those who have received the same qualifying vocational training'.

This definition is contentious and limiting for those jointly trained, as it effectively excludes them from *both* the nursing and social work professions, due to the substantial difference between their training and that of each of the singular routes. On the basis of this definition, jointly trained practitioners would need to establish their own profession, being the only practitioners trained in this way. The same

author recognises however, that a *community of interest* exists among all those who do the same work, and this may provide a clue as to where the professional identity of jointly trained practitioners resides, provided that is, that they remain within or interested in learning disability related services.

Eraut (1994, p.1) describes the professions as a

> 'group of occupations the boundary of which is ill defined'.

This suggests a more flexible position which echoes doubts and uncertainties which exist within professional groups themselves about their roles. These uncertainties can arise from the extension of roles and the changing of services. In the case of joint training they also arise from the change in training arrangements.

Etzioni (1969) identifies both nursing and social work as *semi-professions* and argues that they both possess less autonomy than the traditional professions. Hugman (1998) observes that both groups have *mediated accountability*, their practice being managed to a greater or lesser degree by the agencies which employ them, unlike the more traditional professions. This shared characteristic may have created one of the conditions in which merging of the disciplines has been easier to progress, as neither discipline had such an advanced degree of self regulation so as to prevent this. There was therefore a degree of equity between them.

Both the disciplines of learning disability nursing and social work bear resemblance to Freidson's (2001) *mental discretionary* specialisations, in so far as they require a high degree of specialised formal knowledge consisting of:

> 'bodies of information and ideas organised by theories and abstract concepts' (Freidson, 2001, p. 33)

They also involve the use of discretion to construct or redefine problems. Interestingly, as learning disability services change and integrate, as noted in chapter one, both disciplines also appear likely to gain the characteristic of *transferability*:

> 'which frees specialists from being dependent on work that can be performed in only one place and for only one employer or client'
> (Freidson, 2001, p. 34).

In the field of learning disability new roles are emerging and it can be argued that joint training equips practitioners for this change through a breadth of knowledge which many respondents in this study felt they had. Two respondents held innovative roles, one as a health facilitator and another as a coordinator of voluntary work carried out by people with learning disabilities.

The issue of *independence* or *autonomy* is at the core of attempts to define professions. The *ideal type* professions of medicine and law have, up until now, largely succeeded in eluding the managerialism which has infiltrated services in which many other professional groups are employed. Hudson (2002) states that an important element in understanding professions is the idea that they are able to become organised groups *independent* of employing organisations. Through professional training programmes allegiance can be produced to an authority system different from the organisation which employs the professional. This, it is claimed, develops:

> 'an obeisance to an ideology and to an ideological set of norms, rather than to organisational policies and procedures'
> (Hudson, 2002, p. 9).

The current context of professionalism is changing rapidly, however, and issues of trust, autonomy and the accountability of professionals have never been subject to greater public scrutiny. Irvine (1999) notes there are public concerns over the way in which the (medical) profession has operated self-regulation, protecting doctors rather than patients. O'Neill (2002) describes the culture of suspicion which pervades the relationship between the public and professionals, public servants and politicians. In response to this, greater openness and accountability is expected as the performance and reputations of professionals are doubted. This places limitations on the autonomy of professionals and audit procedures are introduced which frequently aim at

> 'ever more perfect administrative control of institutional and professional life'
> (O'Neill, 2002)

Irvine (2001) states that the new professionalism (for doctors) involves changes in attitudes and practice to ensure compliance to professional standards through a modernised regulatory body which includes lay members.

Decline in the deference and respect for the traditional authority professionals once commanded is also impacting on their hitherto independence (Clarke, 2004). Professionals are increasingly required to negotiate their relationships with the public and with each other. This professionalism is more complex than before and implies

> 'multiple commitments – to the patient, to fellow professionals, and to the institution or system within which healthcare is provided'
> (Royal College of Physicians, 2005, p. xii)

This changing context impacts on both social workers and nurses, who are influenced by the accountability practices of their employing organisations. However, a key aspect of professional identity is also commitment to a code of practice. This, for example, may require the professional to declare where they perceive a conflict of interest between adherence to their code of practice and carrying out duties required of them by their employer. There is a particular area of tension here for the jointly trained practitioner, as to maintain adherence to two separate codes increases the potential for conflict. Dual professional allegiance could present ethical dilemmas for practitioners. Appendix 1 summarises some of the possible tensions and implications for jointly trained practitioners in respect of the duality of their professionalism and suggests a definition of *dual professionalism.*

3.3 Theoretical Perspectives on Professionalisation

According to Evetts (1999) professionalisation is the process of the development of the professions and can be understood as

> ' the series of diverse and variable, social and historical, processes of development of how work sometimes becomes an occupation……and how some occupations achieve various forms of occupational control of work sometimes called professional'
> (Evetts, 1999, p. 120)

This definition indicates the gradualistic nature of that development. Halliday (cited in Freidson, 2001, p. 143) suggests there are two stages in this process. These are firstly the *formative* period when the institutions of professionalism are establishing themselves, struggling to gain official privilege, control of the areas over which they have jurisdiction and their own training. This also includes seeking to establish

> 'labor market shelters'
> (Freidson, 2001, p. 143)

where the professions can exclusively practise. Then comes the *established* period, where the goal is to extend the application of their disciplines. This can lead to internal differentiation that is

> 'driven by the expansion of knowledge, skills and their applications, the invention of new skills, and the variety of practices which develop'.
> (Freidson, 2001, p. 143)

This differentiation is clearly illustrated by the example of nursing, which developed four branches.

Freidson observes that professions are engaged in competition with each other and with other groups in society. The overall strategy of a professional group is to achieve social closure, as

> 'without closure there can be no disciplines'
> (Freidson, 2001, p. 202).

It is through the development of a specialised body of formal knowledge and skill that this closure is achieved. For this to develop it requires a group of like-minded people who learn it, practice it, identify with it and distinguish it from other disciplines. Additionally, the body of knowledge gives the profession the exclusivity required to establish the boundaries around itself, creating a social shelter within which that body of knowledge can be

> 'nourished, practiced, refined and expanded'
> (Freidson, 2001, p. 202).

It is through their knowledge base that the professions are said to exercise the social control of expertise (Eraut,1994), gain power (Freidson, 1994) and in some cases also conspire to create dependent client groups (Illich, 1977). However, neither the knowledge base of nursing or social work is seen as sufficiently esoteric to give either discipline a high level of *indeterminacy.* This is described as an ability to use abstract knowledge and to exercise professional judgement independently, taking the professionals and their actions and decisions beyond the scrutiny of their clients or the lay public (Macdonald, 1995).

The work of Bernstein provides further important insight into knowledge development and the movement towards professionalisation. His theory on the social construction of pedagogic discourse illuminates the process of the development of different disciplines and discourses, ideas which can be related to learning disability nursing and social work. In chapter two the concept of *classification* of knowledge was discussed and how this acts to reinforce the identity of particular categories of knowledge and educational discourse. Bernstein (2000) observes that when the insulation between different categories of discourse is broken, there is a danger of these categories losing their identity. This idea is highly relevant to this thesis because it helps to position the jointly trained practitioner at a possible breach.

Bernstein argues that the principle of *classification* serves to create a social order of weak and strong classifications among the categories, but ironically this order is achieved by a kind of denial:

> '.....the contradictions, cleavages and dilemmas which necessarily inhere in the principle of classification are suppressed by the insulation'.....

and there is developed

> 'a system of psychic defences to maintain the integrity of a category' (Bernstein, 2000, p. 7)

In other words, the classification of knowledge into categories may be necessary to professionals' understanding of the differences between them but may also be self serving. This means that if these defences are strong, different categories will reject

consideration of new or other ways of constructing knowledge which could enhance understanding or, in the case of practice, improve the service delivered.

This theoretical perspective may readily be applied to the knowledge bases on which the professions of learning disability nursing and social work are built. Traditional training for the separate disciplines could be considered the mechanism for *framing* each separate discourse to ensure the continuation of the *singular*, a discourse which is

> 'only about themselves'
> (Bernstein, 2000, p. 9).

Bernstein asserted that what defined a discipline was not so much the characteristics of its discourse but the *crucial space* between that discourse and others. With the *regionalisation* of knowledge referred to in chapter two, *singulars* were recontextualised and new discourses created, changing the classification of knowledge.

These ideas provide a framework with which to understand the bringing together of the *singulars* of learning disability nursing and social work through joint training creating a region of knowledge which is broader (and more holistic) than each of the categories when viewed separately. One of the research respondents in this study who was employed as a nurse said that for a jointly trained practitioner *holistic means bigger* than it does for nurses. In respect of nursing Tschudin (1999) refers to the *holistic relationship*, which is characterised by the nurse's curiosity, optimism and adaptability. However, respondents in this study used the term holistic to describe a broader knowledge than that of singly trained practitioners and many referred to their ability to see things from 'two sides'. Perhaps jointly trained practitioners therefore represent a new, expanded region of knowledge.

Some respondents also talked about being able to cross boundaries and perhaps this demonstrates the capacity to disturb the power relations between categories? As Bernstein argues, it is power relations which create, legitimise and reproduce boundaries. A practitioner who can cross boundaries with relative ease may appear to be a threat or may sense him or herself to be a more powerful one. A Bernsteinian

analysis would place the jointly trained practitioner in the *crucial space* between two professional discourses whose singularity is being called into question by a training which presents the knowledge required for practice in a new way. As he observes:

> 'Regions are the interface between the field of the production of knowledge and any field of practice'
> (Bernstein, 2000, p. 9)

Beck and Young (2005) observe that a characteristic of the current context for the professions is that professional practice is being restructured either through government intervention or the effects of the market. Government clearly has an agenda for interprofessional working, referred to earlier in this study. It has also allowed the internal market to flourish in learning disability services. This context finds purchasers (care managers) working in the same offices as providers (learning disability nurses). Research respondents in this study were drawn from both these types of posts.

Evetts (2006) asserts that a different interpretation of professionalism is now emerging as a discourse of occupational change and control. The concept of professionalism is being constructed and widely used by managers, supervisors and employers to bring about occupational change. This implies changes such as the replacement of professional values by organisational ones, bureaucratic control rather than collegial relations, and increased political control. Evetts describes this as *organisational professionalism* and sees it as a way of managing risk and uncertainty. The other type of professionalism, *occupational professionalism*, is the traditional one, a discourse constructed by professional groups themselves, where

> 'the occupational control of the work [.....] is based on trust in the practitioner by both clients and employers'
> (Evetts, 2006, p. 141)

These two contrasting types of professionalism are in competition. Analysis of the data in my study suggests that jointly trained practitioners encountered both of these in practice, where care management and community nursing met.

3.4 Professional Identity and Changing Professional Roles

The redistribution of roles and tasks, referred to in chapter two as a rationale for IPE, also has implications for professional identity. In contemporary practice roles are increasingly subject to change, impacting on professionalism. This change is exemplified within the National Health Service. Iley (2004) identifies that many of the core skills of nursing are now undertaken by health care assistants, and this has led to lack of clarity about the role of some nurses. It is maintained that this has obscured the core function of nursing. Perry et al (2003) describe ambiguity about the roles of registered general nurses and care assistants. Watkins (1999) states that the expansion of the boundaries of knowledge has meant that there has been an upgrading to professional status for some groups previously regarded as only possessing *associate* professional skills. Amongst these are nurses.

The recent development of primary care services in England provides an example of service and role change, where nurses are taking on aspects of work that were previously the domain of doctors or of other nurses. Rosen and Mountford (2002) identify major developments in the establishment of nurse-led services, the result of which has been to

> 'push forward the boundaries of nursing'.
> (Rosen and Mountford, 2002, p. 242)

Developments have included nurse prescribing, nurse-led clinics in general practice and nurse-led Walk-in Centres. In the case of the latter, the same authors' evaluation identified role similarities between GPs and Walk-in Centre nurses, but with key differences being the importance the nurses placed on communicating with patients, providing advice and health promotion.

Service change can also lead to *role confusion* or *role ambiguity*. This has been the case for some social workers. In a study of team members of integrated Community Mental Health Teams, which in some areas are a relatively new type of service provision, Onyett et al (1997) found that social workers felt confused about what they were supposed to be doing and what the team was aiming to provide.

The introduction of care management into social work in the 1990s also brought about a change in the orientation of some social work roles. This change accompanied the introduction of the internal market into Social Services Departments. This created the split in services between purchaser and provider. In response to this many departments adopted the care management model to carry out their purchaser function (Hugman, 1998). The role of the care manager was perceived by some respondents in my study as restrictive of direct work with clients. Some care manager respondents were unhappy with their role and aspired to do more direct work with clients.

3.5 Professional Identity – the Concept

Although the concept of professional identity is central to this study it is not easy to find a definition of it within the literature. Bendle (2002) asserts that the concept of identity is itself under theorised and as a result it is frequently conveyed as

> 'constructed, fluid, multiple, impermanent and fragmentary'
> (Bendle, 2002, p.1).

Hall (2000) believes identity is socially constructed and as result it is strategic and positional. Hall's definition of *identification* may be helpful in understanding professional identity:

> 'identification is constructed on the back of a recognition of some common origin or shared characteristics with another person or group, or with an ideal, and with the natural closure of solidarity and allegiance established on this foundation'
> (Hall, 2000, p. 16)

This definition would appear very appropriate for those who have trained in single disciplines but may only apply in part to jointly trained practitioners. It appears to give them shared characteristics and identification with a common *origin* and *ideal*, but whether it gives *natural closure* is questionable, as practitioners take different paths on qualification.

Is *pure* professional identity possible? Beck and Young (2005) refer to Bernstein's concepts of *inwardness and inner dedication* and suggest a notion of pure identity associated with *singulars.* Because singular disciplines had a strongly bounded character and they preceded regionalisation of knowledge and were exemplified by

pure academic disciplines, purity of identity was possible. Scholars and professionals could be socialised into subject loyalty and a highly specialised identity.

Hudson (2002) suggests professional identity is generated by practitioners being able to identify themselves with a body of knowledge. This becomes a valued part of individual personal identity which is then nurtured and protected by the profession. But when the body of knowledge changes, is identity diluted and made more difficult to define? Jointly trained practitioners have access to two bodies of knowledge.
The link between professional and personal identity is also made by Freidson (2001), who sees a profession as *extra*-ordinary, defined by the specialised kind of work carried out by its members. This is not just *any* kind of work but work that requires

> 'theoretical knowledge, skill and judgement that ordinary people do not possess, may not wholly comprehend and cannot readily evaluate'.
> (Freidson, 2001, p. 200)

In other words, professional identity is positioned in relation and contrast to lay identity.

Cook et al (2003) describe (nursing) identity as a *developmental process* which evolves throughout a professional career, and they assert that students already have a rudimentary conception of it even before they begin their training. Fagerberg and Kihlgren (2001) also position professional identity in pre-educational orientation. This is said to predict professional development and links to a *paradigm of life,*

> 'comprising our skills, knowledge and interests'.
> (Fagerberg and Kihlgren, 2001, p. 143)

which the knowledge acquired during professional training adds to.

In their concept analysis of professional identity Ohlen and Segesten (1998) identify the link between personal and professional identity found within the nursing literature. They propose that identity comprises external and internal aspects. The socialisation process leads to an *assumed identity* perceived by the outside world, but also the recognition by the individual of an identity within themselves through a

process of *internalisation* (du Toit, 1995). This *personal* dimension to professional identity appears central to attempted definitions of it:

> 'What is meaningful in the nurse's work touches on the identity of being and doing as a nurse'
> (Fagerberg and Kilhgren, 2001, p. 137).

In their research with nurses, Ohlen and Segesten (1998) found self perception to be a key feature of professional identity – what it meant to have a professional identity had an affective quality and was described as

> 'an experience and feeling of being a nurse'.
> (Ohlen and Segesten, 1998, p.722)

For Freidson (2001) the training which prepares the professional creates a commitment such that the professional's work becomes a *central life-interest* and professionals not only exercise a complex skill but *identify* themselves with it. Professional identity is therefore linked to activity which results in some intrinsic reward and the commitment leads to a

> 'distinct social identity and a privileged official identity'
> (Freidson, 2001, p. 102)

Similarly, Tschudin (1999) suggests that identity is linked to the contribution nurses make, which enhances their own wellbeing and personal and emotional growth.

Elsewhere, Freidson (1994) asserts that professional training creates the foundation for a sense of *occupational community.* Even when there are several different career lines that can be followed within a profession (which can divide professional identities and commitments) the training will lead to lifelong membership of and commitment to a profession. Haslam et al (2003) draw on social identity theory to highlight that membership of a group is itself identity defining. Having defined themselves in terms of a particular social identity, individuals then act to preserve the positive distinctiveness of the chosen group.

Professional identity is also said to be influenced by change. Edwards (1997), writing about the contemporary role of adult educators in the changing landscape of lifelong learning, describes how rather than having a single, bounded identity they adopt multiple identities as a way of negotiating the complexity of their working lives:

> 'the identities of workers become multiple, ambivalent and shifting, signifying the complexity of the worlds within and between which they operate. Singular, bounded tribal narratives of identity lose their power to give meaning in relation to this complexity'
> (Edwards, 1997, p. 169)

This idea appears to be very applicable to the jointly trained professional, whose training has been characterised by experiences in two professional fields (of different measure in each individual case) and who emerges into a changing and increasingly integrated world of health and social care. The uncertainty of identity the training engendered (many of the interview respondents said they experienced confusion during the training) could arguably be preparatory for this new working context. Alternatively, the desire for a single, bounded professionalism and its loss or elusiveness may be troubling for some practitioners, denied the comfort of a traditional market shelter. But there may be a dynamic potential in a less bounded identity:

> 'in occupying the space of many narratives and multiple identities.....a different range of possibilities is correspondingly opened up'
> (Edwards, 1997, p. 171)

An identity which is less bounded may therefore be congruent with current working contexts.

Freidson (2001) suggests that the different career paths available to professionals, prescribed by the way that professional institutions are organised, may also have an influence on identity:

> 'the profession can be organised in such a way that early choice among quite different specialities and careers is required which sharply divides professional identities and commitments'
> (Freidson, 2001, p. 102).

This *division* of identity occurs in Freidson's view, when practitioners move into administrative positions for example. He asserts that in this case, despite the career choice made, the initial training received will lead to fairly orderly and stable careers. In the case of jointly trained practitioners, the division is considerably different. The absence of posts requiring their particular qualification meant a divergence between nursing and social work, still two markedly different professional fields in terms of career structures, development and progression opportunities and accountability arrangements.

3.6 Professional Socialisation

In the literature professional socialisation is portrayed as the process leading to professional identity. Meerabeau (1998) identifies two analytical approaches to occupational socialisation. The first of these derives from functionalism and seeks to identify the degree to which professional roles have been acquired as a result of training. Cohen (1981), for example, writing about nursing students, suggests that a key part of the socialisation process is the internalisation of the professional role. She defines professional socialisation as:

> 'the complex process by which a person acquires the knowledge, skills and sense of occupational identity that are characteristic of a member of that profession' (Cohen, 1981, p.14)

This also involves internalising the attitudes and values demanded by the profession. Additionally, the professional culture is said to exert control over individual practitioners by reminding them of their commonly shared ideals.

A relevant feature which may influence the socialisation process is referred to by Cohen as *latent identity*. This is composed of the personal characteristics brought to the process by the individuals undergoing socialisation. This complicates the process because the values and norms which people bring with them to the training programme may influence its outcome.

Cohen believes the socialisation process to be characterised by uncertainty. Even where a final year student feels capable and independent in terms of technical skills, it is possible that they have not yet internalised the professional role and they may be

unable to answer the question – who am I? In these cases they must find the answer in a post educational experience. Given the challenge for joint training students in integrating two bodies of knowledge and having to choose to practise in one rather than the other, they may find it considerably more difficult than singly trained practitioners to answer this question.

Cook et al (2003) argue that nurses who have developed a firm professional identity during their training will be more flexible when faced with role changes in an increasingly complex and diverse society. This argument is logical but also paradoxical. Its validity may depend on the *degree* of socialisation into singular identity and on the individual practitioner's approach. If a firm identity is a secure one, practitioners may have the self confidence to be flexible. If it is a boundaried identity, inflexibility could result. Meads and Ashcroft (2005) suggest that boundaries can be seen either as points of connection or points of separation. How practitioners manage the new integrated context of health and social care provision may depend on how boundaried their identity is.

The second analytical approach to professional socialisation espoused by Meerabeau (1998) analyses how students react to their educational experiences and explores their motivation. This approach is exemplified in a study by Gray and Smith (1999) who present what they claim to be a new theory of socialisation emerging from research carried out with Project 2000 nursing students. The study is useful to my research because it tracks the experience of the students over three years as they progress from the Common Foundation Programme to the Branch Programme and then anticipate practice. Almost all the respondents in my study undertook Project 2000 based training.

A key aspect highlighted in the study by Gray and Smith was that as students progressed they felt an *anticipatory anxiety* prior to practice experiences whilst on the programme and as they were about to qualify, and perceived that their

> 'skill level is very much related to where they have been allocated during their course'
> (Gray and Smith, 1999, p. 644)

Similar anxiety was reflected by some respondents in my study who said they felt a lack of preparedness at the point of qualification, although the important question here is whether this was as a result of joint training or of professional training more generally.

The sense which students make of the education and training process during their socialisation may also be explained by personal construct theory. This theory proposes that people's interpretations of events reflect their own biography and so are personal, but that their experience is also shaped by social identities such as class, gender and ethnicity. This means that our understandings are patterned by our collective experience (Gould, 2000). As members of a 'new' group, jointly trained practitioners may attach great significance to their peer group. Some respondents said that their particular cohort had a strong bond.

Personal construct psychology offers some explanatory ideas which can be applied to the experiences of jointly trained practitioners and to the singly trained professionals who encounter them in practice. Kelly (cited in Gould, 2000, p. 81) identifies the *anxiety* people experience when they are confronted with experiences for which their existing understanding of practice has not prepared them. Additionally, the *threat* experienced by learners when previously held constructs are disconfirmed. *Hostility* is said to be generated when people continue to seek affirmation or evidence for a belief that has already been proven to be invalid. The first two of these aspects could apply to jointly trained practitioners as they move between the paradigms of nursing and social work and seek to understand and integrate the knowledge from two disciplines at different stages of their course. The latter might explain some of the negative reactions to their training which they encountered from singly trained professionals.

3.7 Conclusion

In this chapter the literature on professionalism, professional identity and socialisation has been explored to contextualise the development of joint training and its impact on practitioners who emerge from it. Reflection on the process of professionalisation suggests that joint training may disrupt the equilibrium of the disciplines of learning disability nursing and social work, establishing a new region of

professional knowledge which more fully incorporates both health and social care perspectives in the field of learning disabilities. It has been suggested that professional identity is an elusive concept, potentially all the more so for jointly trained practitioners. If the development of a new expanded region of knowledge goes unrecognised, this may leave jointly trained professionals in uncertain territory, belonging to two regions but not to either, working on the 'border' territory or having to choose one side or the other.

CHAPTER FOUR

Research Methodology

4.0 Introduction

This chapter will focus on the chosen methodology for this study and explore the epistemological stance underpinning the research. It was the latter which provided the rationale for the methodology and methods adopted. The principal methods of data collection will be described and explained. Methods of data analysis will be discussed in respect of the two stages of the research. Finally, ethical issues will be identified and how these were approached during each stage of the research will be outlined.

4.1 Underpinning epistemology and rationale

As discussed in chapter one, this study is about both educational and professional change. In exploring the influence of change, the principal source of data was the experiences of jointly trained practitioners as they reported them. The interpretations of respondents were central to this research, as joint training had the potential to result in quite different outcomes for different individuals involved. Consistent with this, the theoretical perspective underpinning the research was the interpretivist paradigm, as this approach

> 'looks for culturally derived and historically situated interpretations of the social life-world'
> (Crotty, 1998, p. 67)

This paradigm can be justified because jointly trained practitioners are products of a new approach to professional training and professionalism. At this relatively early stage in the development of joint training the graduates are arguably the 'experts' on its effects and outcomes.

The research therefore aimed to explore what respondents' experiences meant to them and how they constructed these meanings. The approach was underpinned by a constructionist epistemology, which holds that

> 'Truth or meaning, comes into existence in and out of our engagement with the realities in our world.[...] Meaning is not discovered, but constructed' (Crotty, 1998, p. 8)

This epistemology reflects the contested and contentious nature of the subject under study. There are no existing explanations about the identity of jointly trained practitioners. Whilst there is literature about those who are singly trained and how they make sense of their professionalism and professional development, there is none in respect of these 'hybrid' practitioners. In the first instance meaning needs to come from them, in order for us to make sense of their experiences. The study adopted an interpretative methodology in acknowledgement that there was not an objective truth about joint training awaiting discovery, but an understanding of meanings for the people involved which required exploration.

The study is both *descriptive* and *explanatory* (Punch, 2000). In terms of description, it aimed to collect, summarise and organize aspects of the subject of focus. Factual and attributional information was collected in order to ascertain the scope of this limited field and to contextualise respondents' experiences. Additionally, by adopting elements of a grounded theory style of analysis (Robson, 2002) the research aimed to build explanatory theory from the data. The methodology was therefore primarily qualitative, although the use of surveys included the collection of some descriptive quantitative data. Denzin and Lincoln (2000) assert that qualitative research involves securing *rich* or *thick descriptions* of the social world, capturing the individual's point of view. The use of interviews as the dominant method of data collection in the research aimed to achieve this.

A combined method study (Cresswell, 1994) or *flexible design* (Robson, 2002) was chosen as this could have a number of benefits for the research. The benefits of such an approach include the triangulation of data from different sources which can neutralize bias, the emergence of overlapping or different aspects of data which can complement each other, and the addition of scope and breadth to the study (Cresswell, 1994). The study drew on aspects of case study research as it focused on students who had qualified from a small number of identifiably similar courses. In order to contextualise the case, attention was given to the historical background to the development of joint training in chapter one.

Robson (2002) observes that features of a 'good' flexible design include rigorous data collection procedures and the use of multiple data collection techniques. A flexible, qualitative approach to research

> 'includes fundamental characteristics such as an evolving design, the presentation of multiple realities, the researcher as an instrument of data collection and a focus on participants' views'
> (Robson, 2002, p. 166)

These are characteristics of this study.

With respect to my role as researcher, it was important for me to establish some detachment from a topic which had interested me for several years. Miles and Huberman (1994) state that in undertaking qualitative data analysis the researcher has

> 'very few guidelines for the prevention of self delusion'
> (Miles and Huberman, 1994, p. 2)

This is an important observation about the researcher as an instrument of data collection, especially where that researcher is a supporter of the case being studied. Having taught on a joint training programme for eight years, the possibility of bias needed to be constantly watched for. Miles and Huberman (1994) believe that it is very difficult for researchers doing interpretative research to detach themselves from the research because they have their own understandings, convictions and conceptual orientations.

The strategy adopted to counterbalance researcher bias was to seek to detach myself by thinking critically about joint training. In the interviews I made an effort to establish an openness that would enable people to talk honestly about the training. I also sought to emphasise to respondents that my connections with the universities which offered the training were now minimal and that I was undertaking the research independently of them. I therefore ensured at interview that respondents knew my background and the fact that I had not worked in a post relating to joint training for four years.

4.2 Data Collection and Sampling

There were two stages of data collection, both involving jointly trained practitioners. In the first stage a questionnaire was sent to practitioners who had qualified from the five joint training programmes currently operating in England (see appendix 2). The second stage involved semi-structured interviews with practitioners who had expressed a willingness to take part in these when they returned the survey questionnaire. Prior to the commencement of the first stage, information had been gathered from programme leaders to establish some background to the aims and rationale for programmes.

The first stage of data collection aimed to locate as many respondents as possible who were jointly qualified, establish their attributes, backgrounds and current work situations, and ask them to comment on the benefits and disadvantages of being jointly trained. It was planned that this would enable a sample of participants to be recruited for the interview stage. Although both the NMC and the GSCC had been asked for help in locating jointly qualified practitioners, it was discovered that neither organization had any record of which particular registrants or certificate holders had jointly trained.

The study lent itself to the use of a *purposive sample*, selected because it would illustrate features and processes that were central to the interest and aims of the research (Silverman, 2000). The sample size for the survey could not be pre-determined and as a result was dictated to some degree by practical constraints (Punch, 2000). The first constraint was the initial challenge to find the practitioners. The only possible route lay through their universities of origin. For reasons of confidentiality, it was only possible to locate the practitioners and distribute the survey via *intermediaries* in the universities in question. These were course leaders, who were sympathetic to the aims of the research. Only they had access to the contact addresses of their ex-students. This placed extra work on very busy educators some of whom were less available to help with this than others.

This unavoidably vicarious method of data collection had four influences on the outcome. Firstly, there were a considerable number of respondents who had only recently qualified (31 out of 47 had qualified in either 2003 or 2004). These people

were perhaps easiest to contact as graduates frequently move away from their universities on completion of their studies and contact addresses may change rapidly. Secondly, it was not possible to be sure exactly how many questionnaires were finally distributed by each university. Thirdly, there were no returned questionnaires at all from ex-students of one university in question. Fourthly, the period of data collection was extended and took place over about eight months.

Forty-seven questionnaires were finally returned, covering graduates from five different universities. This included a small number from snowball sampling I had carried out through my own networks, given that I knew some graduates in my local area. This represented a return rate of approximately 20%, based on an initial mailout of 250. In order to ensure and emphasise anonymity, questionnaires were distributed by each university but to be returned in an addressed envelope directed to the Research Centre at my own university. They were then opened by a colleague and passed to me. The same return process was used where practitioners were located by snowball sampling.

The questionnaire contained a number of open questions which in many cases were very fully and comprehensively answered. I felt that this indicated an enthusiasm by many of those who responded to reflect on a topic of importance to their professionalism. At the end of the questionnaire respondents were given the opportunity to self select to be contacted regarding an interview at the second stage of the research. Thirty-one respondents expressed an interest in being involved in this, although some of them proved impossible to contact or were no longer available to participate. Consent to be contacted regarding the second stage had therefore been given through this self selection process.

Stage Two of the data collection process involved contacting these respondents in order to discuss their involvement, to brief them about the background to the research and schedule a time and place for the interview. This was then confirmed in writing to ensure that consent to participate in the interviews was fully informed. Twenty-five interviews were successfully confirmed and carried out. Those with people who lived in the south east of England were conducted face to face (n=13) and the remainder by telephone (n=11).

When conducting the interviews I sought to establish an informal approach but one based on trust. In respect of the face to face interviews I offered to travel to the respondents' workplace, should they prefer this, and established that interviews would take no more than one hour. This aimed to facilitate the process for busy practitioners and allow them to feel that they were 'on their own territory' and know that the interview was not open ended. Eleven respondents elected for interviews at their workplaces. I hoped that this would neutralise the power relationship that can enter the research process, especially given that I had taught a number of these respondents at one university. My approach to the interviews was to facilitate an open dialogue informed by the idea that

> 'The interview is a conversation, the art of asking questions and listening. It is not a neutral tool, for at least two people create the reality of the interview situation' (Denzin and Lincoln, 2003, p. 48)

I began the interviews by using a very open, informal question asking respondents what they remembered most about their joint training. As the interviews progressed I sought to be flexible with the interview schedule where appropriate so that the conversation could develop naturally. This was consistent with a constructivist approach, which according to Charmaz:

> 'necessitates a relationship with respondents in which they can cast their stories in their own terms'
> Charmaz, 2000, p. 525)

At each stage of the data collection process the data collection instruments were piloted and subsequently amended following feedback from a jointly qualified practitioner. The development of the survey was facilitated by learning from a focus group with final year students on one joint programme which I had carried out for an earlier EdD assignment (Sims, 2002). The interview schedule (see appendix 3) was produced following analysis of the survey data and included questions building on what had been learned from the first stage. One of the outcomes of the two stage process of the research was that of methodological triangulation - using two or more methods of data collection. Cohen and Manion (1989) assert that the benefit of triangulation is that it enables the richness and complexity of human behaviour to be studied from more than one standpoint.

4.3 Data Analysis

Using a grounded theory approach to analysis of the survey data, I was guided by frameworks suggested by Miles and Huberman (1994), relating to *data reduction, data display and conclusion drawing/verification.* They assert that data reduction is itself a form of analysis. In respect of the survey data, open coding involved making analytic choices about which data to code and how to categorise them. Axial coding then enabled patterns to be established which summarised different aspects of the data.

Open coding sought to identify 'meaning units'. These are words or parts of a sentence to which a label can be attached for grouping into sub themes (Fagerberg and Kihlgren, 2001). To undertake this task, the responses to each separate question on the survey were transcribed into a Word document in order to collate together all the responses to particular questions. When collated together in this way the result was approximately twelve pages of text. Axial coding then enabled a number of common aspects to be discerned in respect of practitioners' concepts and ideas about their practice and professional experience. Analysis of these aspects provided insight into what their professional identity meant to them, their perspectives on the skills they held and the influences of joint training on their working practices.

These aspects are presented and analysed in chapter five. This chapter also contains elements of *data display*, where SPSS was used to present charts which revealed some quantitative data supporting survey respondents' written answers to open questions.

Collating text into Word documents facilitated axial coding because it was possible to interrelate answers to different questions and therefore obtain an overview of all the data and discover overarching patterns and themes. This process facilitated *conclusion drawing* in that categories, patterns and themes were rendered 'visible' through the use of highlight pens. A summary sheet of notes was kept of issues arising from the analysis which was referred to during the preparation of the interview schedule and the ongoing data analysis.

The process of analysis of the interview data began with transcription from the digital and tape recordings. I took the decision to do the transcription work myself and believe that this gave me a significant 'feel' for the data. It also enabled me to expand on the field notes I had taken at the time of the interviews with impressions gained as I transcribed. This process had a meaningful effect on my position as researcher. Hearing respondents' voices repeatedly kept the data 'alive' throughout this part of the research process.

The data reduction process in respect of the interview transcripts was much more complex than that of the surveys, due to the volume of data accrued from interviews which generally lasted an hour. In order to establish a framework of concepts and ideas with which to analyse all twenty-five transcripts, I began by selecting eight of these and analysing these for consistently recurring themes/categories. This approach had been suggested by my supervisor as a way of 'letting the data speak'. This was consistent with the process of *selective coding* identified by Charmaz:

> 'Selective or focused coding uses initial codes that reappear frequently to sort large amounts of data. Thus this coding is more directed and, typically, more conceptual than line by line coding'
> (Charmaz, 2000, p. 516)

The selection of these eight transcripts ensured that there was at least one practitioner from each of the different courses and that there was an even balance of practitioners who were working as social workers and nurses. Additionally, one practitioner was working in two settings concurrently and there was one who had 'switched' from social work to nursing and back again.

From this exercise a framework of fourteen concepts and ideas was established which was then applied to all the transcripts. This was done by creating a grid (see appendix 4) listing the fourteen initial categories and then reading all the transcripts and making notes on a copy of the grid in respect of each interview. As analysis developed it emerged that whilst all fourteen categories were relevant they could be refined and reduced to eight key areas. Overlaps between these areas were subsequently identified and the data were further reduced to the five principal themes which will be presented in chapter six.

Consistent with a grounded theory approach, the conceptual categories therefore arose from the data (Robson, 2002). The process involved reading each transcript and analysing them for ideas or content that matched each of the categories. Reflections on the emerging content and ideas were noted during this reduction process. It was this process that revealed that the chosen categories could be reduced further as more focused themes emerged.

The analytical process therefore followed the series of *analytic moves* identified by Miles and Huberman (1994), in that a small set of generalizations covering consistencies was gradually revealed. This grounded theory methodology is similar to Robson's *editing approaches,* in which

> 'Codes are based on the researcher's interpretation of the meanings or patterns in the text'
> (Robson, 2002, p. 458)

The process of analysis developed by applying the themes to each transcript, using coloured pens and tabs to identify significant talk in relation to each. This enabled the group of overarching themes to be gradually identified, each with a number of categories. Labels were given to the themes as appropriate to their conceptual content. After the process of reduction, the five main themes were named as follows: professional identity, holistic practice, interprofessional competence, boundary talk and placement influences.

4.4 Ethical Issues

Punch (2000) observes that all social research involves issues relating to consent and access, and these were the key ethical issues to be considered in respect of this study. Consistent with the Revised Ethical Guidelines for Educational Research (BERA, 2004) I sought to establish the principle of voluntary informed consent at the heart of my study. At the outset of the research I had hoped to gain access to the sample population through the NMC or the GSCC by enlisting their help in sending out a letter with the questionnaire explaining the research aim and context. This method, using a third party, would have detached the research from any involvement of respondents' universities. This was desirable because it could have been that some respondents would not want to participate in research through the organization which

had awarded them their qualification (towards which they may have felt obligation or dissatisfaction). This avenue being closed off early in the process, it was agreed in supervision that I would seek to access the sample population through the universities which were known to have offered joint training.

Course leaders were contacted and agreed to act as intermediaries in sending out the questionnaires. To inform potential respondents fully about the aims of the research, sealed packs containing a letter (see appendix 5) accompanied by the questionnaire and self return envelope were sent to them, for them to label with addresses of ex-students. The self return envelope allowed the recipient to return the questionnaire anonymously directly to a third party at my university, or they could discard it. This process aimed to ensure that consent to any involvement to participate was freely given and the anonymity of respondents preserved. Their identity would only be known if they disclosed it in the interest of being involved in the second stage of the research.

At the interview stage, once respondents had confirmed their agreement to take part in an interview, the details of this and the aims of the research were once again confirmed in writing to them. Prior to the interview they were again asked to confirm their consent to take part in the recorded interview.

An important ethical consideration in my research was the fact that I knew a number of both the course leaders and the respondents. In the case of one of the universities, I had been the leader of the joint training programme over several years, and therefore had taught a number of the respondents. It was essential, given this context, to ensure that the confidentiality of the interviews was emphasised to respondents. For ethical reasons, they were entitled to understand that none of the views they gave would be discussed with other parties and that the recordings of interviews would not be available to anyone except the researcher to hear (and that these would be destroyed at the end of the research). Neither would they be named nor any comments or quotations be recognizably attributed to them. Prior to the commencement of each interview, as well as checking that they were still consenting to be interviewed, I informed respondents of these aspects of confidentiality.

This matter of confidentiality was a methodological issue as well as an ethical one. Without a relationship of trust, established through guaranteed confidentiality, it is unlikely that the open conversation I sought to have with respondents would allow for free expression of critical views. In the survey, respondents had been critical of their courses, and this critical edge was important to my research, although it must be acknowledged that respondents who studied on the programme I led might be more reluctant to criticise it in my presence. This is one of the dilemmas of the aspect of 'insider' research this study entailed.

4.5 Conclusion

This chapter has explored the rationale for the methodology adopted in this study and has discussed how the research was operationalised in a way consistent with a constructionist epistemology and an interpretivist paradigm. The two stage design of the research was discussed and methods of data collection and analysis explored. Ethical issues of access, anonymity, confidentiality and insider research were identified and the strategies for addressing them discussed.

In the two data analysis chapters which follow individual respondents are referred to by a numerical identifier. The prefix 'S' refers to respondents from the survey stage of the research and the prefix 'Int' to respondents in the interview stage.

CHAPTER FIVE

The Survey – Presentation and Analysis of Data

5.0 Introduction

This chapter explores the results of the first stage of data collection by presenting and analysing the data obtained from the survey. Forty seven questionnaires were returned by graduates from five different universities/colleges. Analysis involved close scrutiny of the texts to establish common themes and perspectives. Tabouret-Keller (1997, p. 315) states that

> 'Language acts are acts of identity'

Guided by this idea, analysis of the words and descriptions used by respondents had the potential to give clues to an emerging discourse about jointly trained practitioners. Where appropriate, SPSS was used to reduce quantitative data to descriptive statistics to support the analysis and to display responses which would complement it. The data will be presented under a number of headings which are indicative of the themes which emerged during analysis. Attributional information about the respondents was collected during the survey. Characteristics of the sample are displayed in appendix 6.

5.1 Professional Identity

Respondents were asked to describe their professional identity by selecting a category from a small number of possible choices. The data revealed that the majority of respondents divided almost equally between describing themselves as a nurse, social worker or a joint practitioner (see Figure 1 below). Asking this question, however, appears to have led to some 'idealised responses', (how respondents would *ideally* like to describe themselves) because at the interview stage they generally used their job title to define themselves, many pointing out that if they called themselves a joint practitioner other people would not know what they meant and that this would conflict with their job title and role. This difference between the survey and interview

data suggests a source of some conflict for those jointly trained, who felt unable to practise in the way they were trained to.

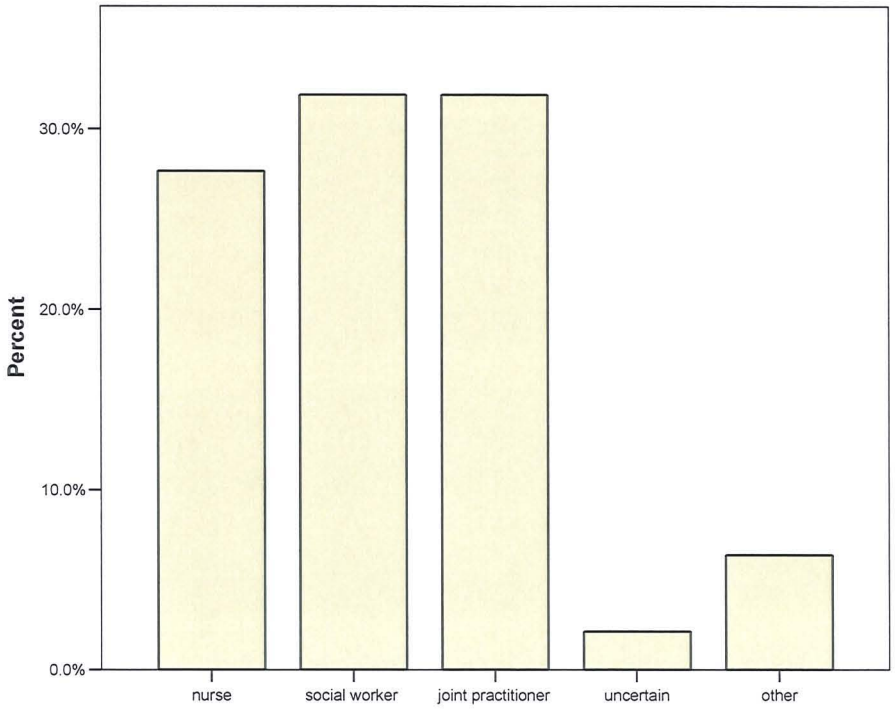


Figure 1. Respondents' professional identity

5.2 Breadth of Knowledge

In chapter two, Bernstein's concept of the regionalisation of knowledge was referred to as a way of explaining new and different ways of knowing. The survey results suggest that breadth of knowledge was a key outcome of being jointly trained and was perceived as one of the benefits of the training. In the surveys the word *knowledge* featured thirty-two times in response to different questions, frequently linked to the expression 'health and social care'. Responses revealed that practitioners tended to compare themselves with singly trained colleagues, suggesting a sense of their identity derived from that comparison.

Dominelli (2004) notes that we come to understand our own identity through comparisons with others. In relation to knowledge, many respondents wrote their responses comparatively and considered themselves to have a 'broad', 'increased' or 'wide' knowledge base (n=6), to have a 'wider' or 'broader' knowledge base (n=7) or to have knowledge that was described in terms such as 'more in depth' (n=1) or

'more rounded' (n=1). This breadth of knowledge was characterised by different respondents in different ways. Responses indicated this and included the following:

'good, broad knowledge of the lives of people with learning disabilities' (S02)
'you can apply theories from both disciplines to practice' (S03)
'understanding the workings of both the NHS and Social Services' (S12)
'knowledge of social and health care legislation' (S14)
'understanding of two professional roles' (S35)
'multidisciplinary knowledge' (S33)
'broader overview of health and social care issues' (S39)
'knowledge of nursing and social models' (S31)
'I have a holistic approach and rounded understanding of issues from both a social and health perspective' (S28)

Most of these expressions indicate the duality that joint training implies, suggesting respondents constructed their professional identity from a broad knowledge informed by the two paradigms of health care and social care. For individuals working as social workers in particular, it was knowledge of the health side that was particularly beneficial, as they were able to bring this to their social work practice, making it more holistic than other singly trained practitioners could achieve. One respondent claimed to be able to

'more easily consider health issues than other social workers, for example, pain and medication'. (S30)

Another social worker stated that

'training as a learning disability nurse gives me the advantage of knowing how certain health conditions affect the service user and what care package to put in. I am able to use my skills and experiences as a learning disability nurse in community care assessments'. (S10)

Figure 2 illustrates that a significant number of respondents felt that the training had prepared them well for dealing with health issues in practice.

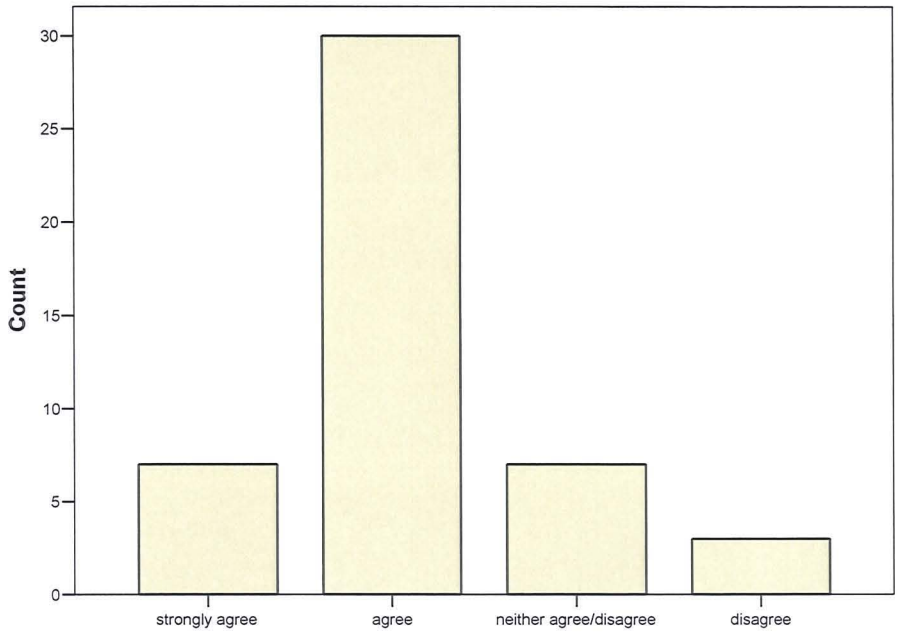


Figure 2.Respondents felt well prepared for dealing with health issues

When asked specifically to identify whether service users had benefited from respondents' joint training, eighteen responses included the words 'medical', 'nursing' or 'health' to describe some benefits. Seven of these respondents referred to their ability to assess or look at health issues or needs, six saw benefits in their understanding of health and five referred to interventions such as advice giving or health promotion.

This question appears to have drawn out the explicit significance of health knowledge to the identity of those working as social work practitioners. Of the eighteen respondents referred to, fourteen were practising as social workers and one was working for a Social Services Department as a transition coordinator.

Health knowledge had particular benefits for two practitioners in that they felt able to challenge health professionals. One commented:

> *'I have supported service users to obtain the most from health professionals and resources available. I have challenged health professionals who have treated people with learning disabilities in a way that is discriminatory'.* (S42)

Another respondent saw a benefit in not being

'blinded by science from other health professionals'. (S28)

These responses suggest that their knowledge was sufficient to enable the practitioners to hold a confident, informed perspective helpful to achieving the positive outcomes for service users. Knowledge of health was evidently a significant benefit arising from the programmes and for those employed in social work appears to have been a distinguishing feature of their professionalism.

5.3 The Risk of Losing Skills

Some practitioners were concerned that the training had not been sufficiently in depth in respect of both the professions (n=3). Three other respondents used the term 'Jack of All Trades' to describe the feeling of having insufficient in depth knowledge. One of these respondents felt that this was how she was perceived by others. Three other respondents described the fact that they felt they were losing or likely to lose skills in one area because they were only practising in the other.

This potential loss of skills appeared to apply more to nursing skills than to those of social work. In the quantitative part of the survey, a greater number of respondents felt they were losing their nursing skills than their social work skills (see figures 3 and 4 below). This may reflect the fact that a larger number of respondents were employed in social work than nursing, where there was little opportunity to keep up to date in their nursing practice.

In the light of this reported loss of skills, establishing the wide knowledge base as a general characteristic of the identity of a jointly trained professional is therefore problematic and needs to be viewed in the context of other responses in the survey. In contrast to the feeling that was expressed about having a broad knowledge base, another pattern of responses revealed concerns about gaps in their knowledge and the fact that they felt at risk of losing skills that they had no opportunity to practice or develop. These concerns appeared to come from the fact that the majority of practitioners had to choose to practise one profession on qualification, except where they were able to work part-time in both. Gaps in knowledge would therefore remain if there was no opportunity to practise or develop skills.

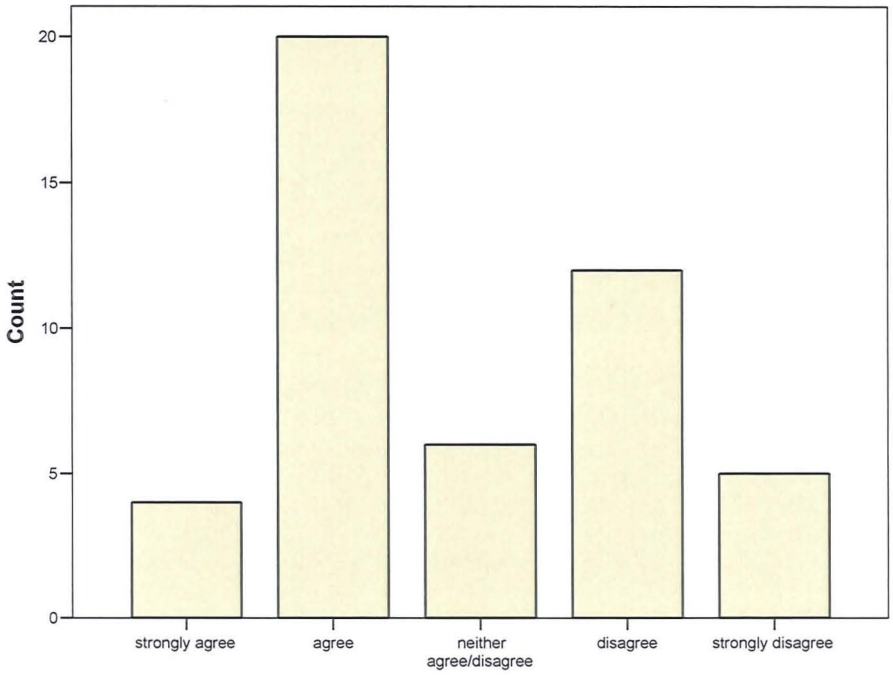


Figure 3. Respondents felt they had lost nursing skills

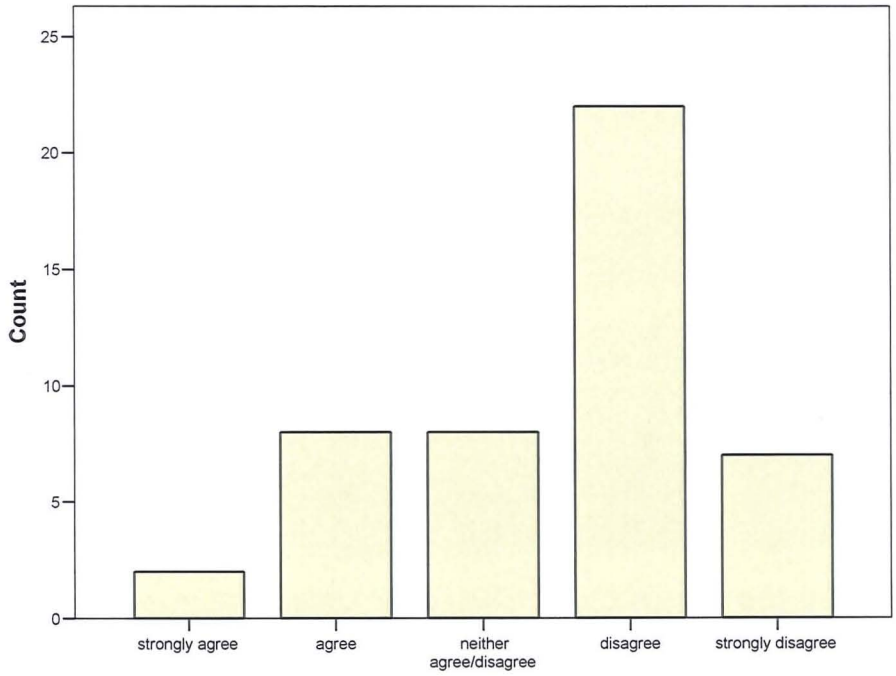


Figure 4. Respondents felt they had lost social work skills

Survey responses suggest that a number of students felt unprepared in one or other of the disciplines by the end of their training. Two respondents did not feel fully prepared for either discipline, four were concerned about gaps in their knowledge of or preparation for nursing and four had similar concerns about social work. This

apparent even balance was contradicted by the quantitative aspect of the survey, which revealed that more respondents (93.6%, n=44) felt well prepared for social issues than for health issues (78.7%, n=37).

In terms of preparedness for practice, one respondent felt that the training

'tilts in favour of one area'. (S39)

This might set the practitioner on a particular pathway towards either nursing or social work. Perhaps as a consequence of this, three respondents felt that one of the challenges for them once qualified was to immediately develop their skills further in their chosen area. One nurse had to spend time

'catching up on the information specific to nursing'. (S02)

A social worker described

'getting up to speed' (S08)

with law and child protection, and a second social work practitioner wrote about

'having to learn faster in a work environment' (S41)

because work placements during the training had not given sufficient opportunity to learn all the skills needed for the discipline.

5.4 Forced Singularity

In the national audit of joint training courses referred to in chapter one (Webber and Taylor, 2000) an espoused benefit of joint training was the integration of health and social care practice. However, a significant issue for many survey respondents in my study was the difficulty in finding a job in which they could practise and continue to develop both sets of their skills. This placed limitations on the opportunity to practise holistically. As one respondent explained, once employed

'only the discipline you are practising appears to be recognised'. (S03)

Eighteen survey responses alluded to the difficulty in getting jobs where both sets of skills could be used, which was perceived as one of the disadvantages of having done joint training. Only 8.5% of the respondents (n=4) were in posts where joint training had been advertised as one of the qualification requirements.

Having to choose one profession and leave the other behind was perceived by four respondents as one of the challenges of joint training. One respondent identified the disadvantage of

'lack of professional identity and being forced to be either identified as a nurse or social worker'. (S19)

The practical challenge of being jointly trained was summed up by another respondent:

'Finding a role that you can use both skills without deskilling yourself – I feel torn between two professions. I would like to do both in a single job and be respected as such'. (S36)

This aspect of *forced singularity* was identifiable in a small number of the responses, namely the feeling that jointly trained practitioners were constrained in their single roles. 42.5% (n=20) of survey respondents did not believe they had used all the skills learned during their training. Singularity of role appeared to present dilemmas for jointly trained practitioners, in that in some work situations they had the potential and the knowledge to do more than their job description and the accountability arrangements allowed. One respondent referred to a

'pressure to stay within a single professional boundary'. (S23)

Another, employed as a social worker, identified a specific dilemma:

'at times I know what advice to give to carers, but because I am not working in my capacity as a learning disability nurse I am not able to do so. In the current situation you are either employed as a nurse or as a social worker...even where

you may want to do both jobs without being paid the amount of caseload you have will not give the time to do so. Should something go wrong one will not be protected as the individual is not employed as a learning disability nurse'. (S10)

This suggests a recognition of the risk to a practitioner from crossing boundaries coupled with a boundary awareness which was very clear. The dilemma illustrates the potential for ethical issues to arise from ambiguity of identity. The issue of advice giving suggests conflict for the jointly trained practitioner. Where they are employed as a social worker there could be times when it is in the service user's interest to give advice without the delay of the referral process. Such a situation could place the practitioner in an invidious position in respect of their professional accountability. This may be one of the complexities of the 'new professionalism' and the role overlap it inheres.

There was a particular dilemma for social workers when carrying out community care assessments. Although social workers had reported the positive benefits of health knowledge to their practice, one respondent said that even though health needs were identifiable there was sometimes an obligation to put 'no community care needs identified' on the assessment. This was because health needs were not considered a priority in community care assessments. This suggests that the jointly trained practitioner may at times be torn between what they are trained to do, namely to assess holistically and evaluate all aspects of client care, and what their particular service employer requires them to do. In this situation, they may stand uncomfortably at the point where health and social care divide. Another respondent described one of the challenges of being jointly trained as

'doing assessments with the focus on only social needs'. (S06)

This appeared to be a significant issue for some of those who had taken a career pathway into social work and it illustrates a clear paradox in terms of the rhetoric of the training versus the reality of practice.

5.5 Bridge Builders, Boundary Crossers, Peacekeepers

Despite the sense of forced singularity described above, a *duality of identity* pervades responses in the survey, frequently linked to ideas of opportunity and advantage afforded to those jointly qualified. 78.7% (n=37) of respondents believed the training had given them an advantage over traditionally trained practitioners. For some practitioners identity was conveyed through *constructive* metaphors suggesting a sense of uniqueness. One answer appears to capture this well:

> *'The experience gives you so much and it cannot fail to give you greater insight into both areas. There are limitations trying to bring the two together but it certainly gives you a real sense of the possibilities and challenges'.* (S39)

As discussed earlier, responses about the benefits of joint training were frequently framed in terms of duality. A particular area of advantage was in terms of inter-professional work. Some quotations suggest respondents ascribed to themselves characteristics of active inter-professional engagement. For example, one respondent spoke of

> *'the ability to understand both professions and having the skills to build effective bridges'.* (S02)

Another person suggested ease of movement between the territories of health and social care:

> *'I can work across professional barriers'.* (S25)

Another practitioner refers to

> *'being able to work to keep the peace between health and social care professionals'.* (S18)

Duality of perspective was portrayed as an advantage in that it could enhance the single roles that practitioners were obliged to work in. This suggests an inter-professional dimension to professional identity. A practising social worker stated:

> *'I have the advantage of combined skills from both professions'.* (S10)

A nurse stated:

> *'I have a holistic approach and rounded understanding of issues from both a social and health perspective....I am also aware of which professionals to refer on to, therefore preventing people enduring pillar to post situations. People feel comforted and assured by my nursing status'.* (S28)

One respondent claimed that the understanding of different professional cultures and language led to innovation and creativity. Another, employed as a nurse manager of a multidisciplinary team, said the training had led to:

> *'the ability to think, plan and problem solve more laterally, which I believe will result in longer-term and more stable solutions for clients'.* (S24)

A key benefit of the training identified by several respondents was their *interprofessional understanding*. There were three different dimensions to this. Six respondents referred to their understanding of systems or services, which was perceived to be enhanced because of the joint training. This was referred to by one person as

> *'a much greater understanding of the broader context of health and health and social care provision'.* (S24)

Nine respondents referred to their increased understanding of the roles of other professionals. Nine other respondents referred either to their understanding of both professions (n=2), an ability to relate better to other professionals (n=3), or an awareness of nursing/medical professionals (n=4). The inter-professional perspective enabled one social work practitioner to empathise with colleagues working in the alternative discipline, making her

> *'aware of problems nursing colleagues face (and) less precious and aware of other professionals and the input they can offer as well as their limitations'* (S46)

There was a very consistent view that the training had prepared the practitioners well for dealing with inter-professional issues. This is indicated in figure 5, which demonstrates that 91.5% (n=43) of respondents believed the training had prepared them well for inter-professional working. Its value to their practice is suggested by the fact that in another part of the survey 25 respondents identified interprofessional

working as one of the areas of knowledge and skills they used most in their current work.

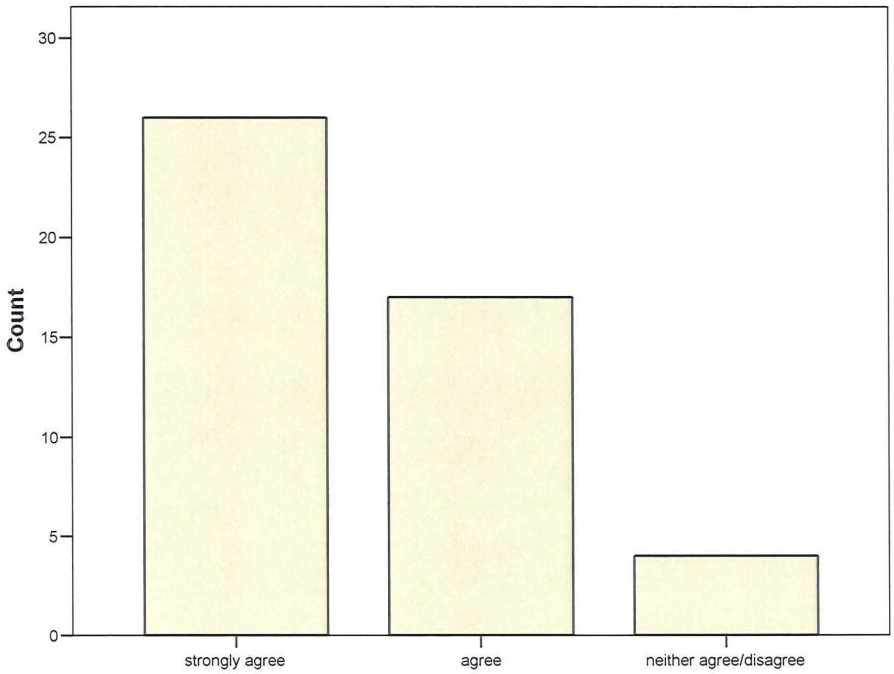


Figure 5. Respondents felt well prepared for interprofessional working

There were also other interprofessional benefits derived from joint training which were referred to by respondents. The ability to network with other professionals was cited by two respondents. Other responses indicated the ability to challenge other professionals (n=2) and to deal with other professionals or the multidisciplinary team (n=6).

Reflecting the *comparative* way in which jointly trained practitioners seemed to construct their identity, one respondent claimed the ability to

> *'work more closely with the health professionals in my team than other social workers'.* (S40)

5.6 Misunderstood Practitioners

Another aspect of the identity of the jointly trained practitioner appears to be bound up with the idea of *being held back* not only by the absence of jobs which allow the practitioner to practise using their breadth of knowledge and skills, but also by lack of recognition and understanding of their training by others, be these colleagues or

employers. A sense of not being understood comes across consistently from the survey responses.

Survey questions relating to the disadvantages and challenges of being jointly trained revealed this. Eleven responses referred to the lack of recognition by others of the value of joint training and sixteen to a lack of awareness or understanding by colleagues or employers about joint training. Three respondents felt that colleagues were suspicious of the training. One respondent may have captured a shared experience when saying:

> *'some professionals can't accept that jointly trained professionals are properly trained'.* (S10)

Another referred to having to defend joint training

> *'when it is receiving negative comment'.* (S18)

Four respondents practising as nurses referred to the negative reactions of other nurses. One stated that

> *'general nurses don't think you are a proper nurse'.* (S36)

Another had tried

> *'not to be offended by the assumptions, misgivings and apparent fear... ...encountered from community nurses'.* (S28)

A third found that one of the challenges of joint training involved

> *'trying to convince the nurses that I am as passionate about health issues as I am about social issues'.* (S05)

The fourth person said that other nurses questioned how the respondent could have gained a qualification in nursing when compared to their own training, given that the trainings lasted the same number of years but the respondent's included social work

as well. In chapter three it was suggested that change can trigger defence mechanisms. These encounters with other professionals are suggestive of this.

5.7 Embodied Duality. The Holistic Practitioner.

Fourteen respondents used the term 'holistic' to describe either an advantage of being jointly trained or its benefits to service users. There were three dimensions to the way in which the word was used. Six people said the joint training had given them a holistic approach, view or perspective. One of these characterised this as having a realisation of wider political aspects to care and how these influence an individual's life. Five respondents said joint training led to holistic care, service, treatment or assessment. One of these was a social worker who characterised a holistic orientation as almost inevitable:

> *'I cannot help but consider nursing assessments when completing the health section of a social work assessment'.* (S35)

A further three respondents referred to the holistic knowledge they felt they had gained through joint training.

Analysis of the survey responses in relation to skills acquired through the training reveals a sense that for many of the respondents there had been advantages for their practice. A consistent pattern of responses concerned the value of being able to use knowledge and skills from *both* disciplines in respondents' practice. This duality appears to have created an extra dimension to practice in the view of some respondents. This was described by one practitioner as the ability

> *'to marry both views'* (S04)

and another as the

> *'advantage of combined skills from both professions'.* (S10)

Combining the skills appeared to produce a synergy resulting in this intangible other dimension. Brown (1993, p. 3190) defines synergy as

'increased effectiveness, achievement [....] produced by combined action'

although this normally refers to work with other people. What is interesting here is that there appears to be an *internal synergy* derived from dual professional knowledge.

Nine respondents perceived a value in being able to bring the two different perspectives together to benefit their assessments or their care planning. For two respondents there appeared to be an elliptical reference to such synergy. One commented as follows:

> *'I think having both professions allowed me to explore areas which perhaps I wouldn't have without'.* (S09)

The other saw an advantage in being able to

> *'work in a slightly different way, bringing a more involved perspective when working with service users'.* (S17)

Three respondents used the term *creative* and two the word *flexible* to describe their practice, suggesting a perceived difference in approach rendered possible by their training. Two others referred to *lateral thinking* as a benefit arising from joint training.

Other survey responses suggested a sense that knowledge of one set of skills complements the other, and that this gives an

> *'understanding (of) the impact of health on social care and vice versa'.* (S41)

This meant that skills were transferable because of the

> *'degree to which health and social needs are interwoven and can't in many cases be separated'.* (S44)

For one respondent their practice seemed to come close to one of the original possibilities of joint training:

'people with learning disabilities have one practitioner rather than a nurse and a social worker. I can provide health and social advice/intervention'. (S05)

This echoes the potential of holism, which has been defined as

> 'involving the treatment of the whole person rather than the physical symptoms alone'
> (Brown, 1993, p. 1248)

The complementary value of two sets of skills, even when a respondent's job role only required a single set, was captured by one respondent who stated:

'What I am trying to say is that the broad range of knowledge gained helps me to be a good social worker even if I do not pursue a nursing career'. (S09)

Working in a mental health team, she saw herself as embodying the two perspectives when working with people to carry out a comprehensive assessment:

'I think our health and social care comprehensive assessments which are carried out by health and social care workers are effective. They look at all of an individual's needs. I think I am a continuation of this when I am working alone with people. Unlike a singly trained social worker, I actively look for health needs'. (S09)

5.8 Particular Knowledge and Skills

In terms of particular skills or knowledge and the benefits of being jointly trained, five respondents specifically cited knowledge of legislation as one of these and seven people identified knowledge of health as a particular benefit. With reference to the latter, the responses related to health needs (n=2), health conditions (n=2), health promotion (n=1) and health issues (n=2).

In one section of the questionnaire, respondents were asked to identify key areas of knowledge and skills which they used most in their current job. They were asked to select ten items from a list of 39 categories. There were few significant patterns, but it was noticeable that the most frequently identified categories were those of communication (n=38) and inter-professional working (n=25), suggesting the importance of these to practitioners' roles.

The next two most selected categories were those of using values and anti-discriminatory practice (n=22) and empowering, promoting and enabling (n=22), suggesting that these elements of a philosophy of care were central to many respondents' professional identity. That philosophy of care may also have incorporated the concept of teamwork across boundaries. The category of teamwork was selected by twenty-one respondents.

5.9 The Impact of undertaking a Joint Programme

There was a view expressed by some respondents about the increased stress levels in undertaking a joint course (n=2) and about the heavy workload (n=2). Three respondents recalled their course as being either poorly organised or disjointed. One commented on the lack of integration during their course:

> *'I feel joint training is very beneficial, however, the college work needs to be integrated together. Each semester seemed harder and I had to either concentrate on my social work portfolio or nursing'.* *(S21)*

One respondent was particularly dismissive of joint training, which it was felt looked good because of the

> *'letters after my name but only gave the ability to waffle about empowerment'.* *(S16)*

He felt the course lacked practical skills such as knowledge about medication. This person felt he would have been better off if he had done a single nursing programme. A further three people expressed concern about inadequate or inappropriate placements and felt they could have been better prepared for current practice.

In contrast to some of the criticisms of the courses, one respondent inferred that the intensity of study was itself developmental. It was observed that the demanding nature of the course

> *'set me up for the rigours of practice'.* *(S08)*

There was also, however, a positive aspect to being jointly qualified in relation to employment. Four respondents observed that joint training gave the practitioner more job choices because of the potential to work in either health or social care.

Respondents were asked in the survey whether they wished they had done a single training course. 78.7% (n=37) of respondents disagreed, including 21 respondents who strongly disagreed. Three people agreed (6.4%), two of whom strongly agreed.

5.10 Conclusion

By exploring the survey data through analysis of the language used and ideas expressed by the respondents, a number of themes emerged. Expression of professional identity was divided almost equally between social worker, nurse and joint practitioner but was characterised by some ambiguity. However, many respondents perceived their practice as holistic, describing a duality which encompassed both health and social care knowledge and skills. This suggests they perceived boundaries between their two areas of knowledge as points of connection (Meads and Ashcroft, 2005) and had developed an identity based on this.

Despite a breadth of knowledge, however, some respondents were uncertain of some of their skills and felt they were losing these, being unable to practise or develop them in the single professional roles they were forced by circumstances to take up. Paradoxically, they were obliged to work in one or the other discipline, restricted by the boundaries of role. There was therefore some unresolved conflict for respondents. Additionally, some felt that at the point of qualification they were not fully prepared for practice in one or the other discipline and there was a consistently held view that other practitioners did not understand joint training and some perceived it negatively.

CHAPTER SIX

The Interviews – Presentation and Analysis of Data

6.0 Introduction

In this chapter I will present and analyse the data from the second stage of data collection, which involved interviews with twenty-five respondents who had jointly qualified in learning disability nursing and social work. Five themes were identified as the process of analysis progressed. These related to professional identity, holistic practice, interprofessional competence, boundary talk and placement influences. This chapter will present and explore these themes in chronological order, with reflection on the evidence they provide about respondents' professional experiences since graduation. Attributional information in respect of the interview respondents was collected and can be found in appendix seven.

6.1 Professional Identity

6.1.1 Shifting Identities

Building on questions about identity asked in the survey stage of data collection, respondents were asked during the interview which profession they most identified with. Of the 25 respondents, 9 said they identified with social work, 11 with nursing and 2 with both. Of the three remaining respondents, one identified with neither profession, having worked as a trainer for many years, another described himself as an NHS clinical practitioner and the third, who was employed as a forensic CAMH practitioner, felt that his identity was

> *'fluid and depends on what environment I am in'.* *(Int15)*

This expression of a *contingent* identity was unique in the sample studied, but there were other respondents who qualified their statements about how they perceived their identity and rendered it ambivalent or ambiguous. Some examples were:

'for me it is [...] not relying on a specific professional identity to feel confident' *(Int 23)*

'Both now [...] although I have done five years of nursing and only two of social work' *(Int 12)*

'I identify with both but I practise as a nurse at present' *(Int 21)*

'At the moment nursing because I am employed as a nurse' *(Int 11)*

It was noteworthy that not every respondent necessarily identified with the profession in which they were currently practising. This may reflect the diversity of roles held within the sample studied and the fact that a number of the respondents had practised as both a nurse and a social worker since qualifying. It underlines the complexity of identity which emerges from dual socialisation.

Whilst in the survey almost one third of survey respondents had described their identity as that of 'joint practitioner', this was not the case amongst the interviewees, only two of whom said they used the term to refer to themselves. A number of respondents acknowledged, however, that this was a term commonly used during the training and two said that they had originally used this term when they qualified.

Five people stated that it was more appropriate to refer to yourself as what you were employed to be. Different respondents gave reasons for not using the term joint practitioner. This was because it was not recognised, not understood and no paid roles existed for it. Six people said that they called themselves jointly *qualified*, one of whom believed there was an accountability issue which could not be avoided:

'I have never referred to myself as a joint practitioner because I think it's a misnomer. I am jointly qualified but .....to say you are a joint practitioner suggests that you are able to do both (nursing and social work) in your current job and I think it is safe to be quite clear about the professional boundaries' *(Int 12)*

This respondent had done five years of nursing and two of social work since qualifying and felt that although he identified with both professions he would describe his job to people as whatever he was doing at the time. Given that none of the research respondents were in roles where they were allowed to practise both disciplines, this respondent's view illuminates the importance of terminology in the

field of joint training, suggesting that the term 'joint practitioner' is aspirational (and derives from education) rather than functional within practice.

A respondent who said she identified with both professions was one of a small number of those who were currently practising in both fields. She was working as a full time social worker in a Disability Team and at the weekends as a part time 'bank' learning disability nurse. She described herself as a kind of 'hybrid' practitioner, the term used by Brown (1994). Given that this respondent later in the interview expressed her intention to move fully into nursing, she qualified her view with the words:

> *'I guess from now on in I am more of a nurse than a social worker'.* (Int 20)

The way this is phrased suggests movement in identity and reveals the ambiguity of the concept discussed in chapter three. Overall, like this person, interviewees generally located their professional identity in the role they were presently carrying out and not in the idealised role they had hoped would be open to them. It was therefore job role that defined their *assumed* (and singular) identity. However, some interview responses revealed negative aspects characteristic of their *internalised* identity (du Toit, 1995).

One such negative aspect was the sense of aspiration accompanied by disappointment about the lack of opportunities to practise jointly. This was very tangible in some of the interviews. Three people talked of their frustration and disappointment about this. The practitioner who was the earliest of all the respondents to jointly qualify encapsulated that disappointment:

> *'There was a certain feeling that we were doing something that was pretty special. I think that the reality hits though when you go into the workforce and there isn't actually an identified or dedicated post for a joint practitioner'.* (Int 07)

Echoing the findings of the survey, another respondent was concerned about neglecting one side of what he was trained for whilst a further person felt she would lose her clinical skills as she could not practise them as a social worker. Having to

choose one professional pathway after being trained in two was at the heart of these concerns:

> *'I think in some ways it is a disappointment because you feel like you have to choose. Because you have dedicated your time to learn how to do things jointly it feels really unfair that you have to get to a point where you have to choose. And you have to almost let one of your qualifications fall by the wayside unless you are able to do relief work to keep the other one going'.*
> *(Int 17)*

One respondent, practising as a social worker, identified another important dilemma for the jointly qualified practitioner, namely that of losing registration with one of the two professional bodies if you did not practice in that field. She described this as the

> *'saddest thing about the whole course'. (Int 06)*

Information from the survey had identified that only 26 respondents were registered with both professional bodies (the NMC and the GSCC). Maintaining registration is now a requirement for both social work and nursing as both have protected title. For practitioners this clearly represented a challenge in terms of their professional recognition and the lack of opportunity to capitalise on the duality of the training and maintain both 'sides' of their professional identity. Given that the registration process for social work only began in 2003/4, this may be a particular challenge for practitioners who qualified significantly before that time and have worked as nurses ever since then. Some respondents were concerned at the cost implication in maintaining two professional registrations as an annual fee has to be paid for each.

6.1.2 Identity Confusion?

Whilst there were concerns about the disadvantage of being unable to practise in two professions at once, there was little indication from the interview data that practising professionals were confused about their role or identity. Although there were several references made to having experienced confusion about their identity *during the training*, there was evidence that respondents were working within roles prescribed by their current employment and were very aware of their accountability and boundaries of their responsibility. In the interviews 17 respondents stated that they were not confused about their professional role or identity.

Only one respondent felt that she was confused about her role ('sometimes'), having moved into social work from a learning disability nursing post. Five other respondents had initially felt confused at the beginning of their first jobs after qualifying. One of these identified some dissonance between his expectations and the reality. His tutors had told him and his fellow students that they were joint practitioners but he reappraised this:

> *'I am quite certain that I am not a joint practitioner. I am a joint qualified practitioner in a single field'.* (Int 12)

Following the criteria of their current role appeared to be a strategy employed by respondents to manage any ambiguities of identity.

Paradoxically, the frustrations indicated above at not being able to practise jointly seemed to demonstrate respondents' awareness of the professional boundaries which defined their roles and restricted their ability to use all of their skills. It appeared that confusion resulted not from gaining two professional qualifications simultaneously but from raised expectations that they should be able to carry out a role that has never been defined. This was consternation rather than confusion. One social worker commented that she was confused

> *'if I think about the idea of being a joint practitioner. The reality is you cannot do both things at once. I am not sure whether it is possible to create a post where this can happen because of legal constraints'* (Int 09)

Seven of those interviewed explicitly aspired to undertake a joint role. Additionally, eight respondents wanted to work in nursing but had been unable to find posts due to their local unavailability. Two people had had to go back into residential work as a part of an agreement with their sponsoring employer but had found this limiting and had in due course moved into community nursing.

6.1.3 Readiness to Practice

Consistent with the survey results, respondents revealed elements of initial anxiety and nervousness at the point of qualification, as well as feelings of lack of preparedness especially with regard to clinical skills. There was however, after initial self doubt, a realisation that the training had been valuable.

Eight respondents spoke of feeling anxious, nervous or challenged on commencement of their first post after qualifying. One person described a mixture of excitement and trepidation because of the

> *'huge leap going from a student and all of a sudden you have got your pin number and you are now an accountable professional practitioner'.* (Int 11)

For four respondents these feelings were seen as a natural trepidation in the newly qualified practitioner and not specific to having undertaken joint training. They were part of the transition from the protected status of student to the role of independent practitioner. One person thought the feelings of nervousness were linked to the expectations a practitioner has of the knowledge they should hold:

> *'I think sometimes you put pressure on yourself when you have just qualified but a lot of your knowledge comes from experience'.* (Int 17)

There were, however, twelve respondents who said they felt unprepared for practice, needed more knowledge, or were weaker in one discipline than the other. It was significant that nine respondents mentioned weakness in the area of clinical or nursing skills, but only two referred to this in terms of social work. This reflected a similar trend in the survey data. One person felt unprepared for both disciplines.

Six respondents specified areas of nursing skill in which they did not feel ready. Two were not confident in giving injections and two lacked confidence in their knowledge of medication. One person said there were nursing techniques such as the delivery of rectal diazepam and enemas that she was required to do in her job that she had never practised as a student, and had consequently had to learn these very rapidly.

A further respondent, employed as a social worker, took a philosophical view about how to manage skills deficits. If she lost any skills she could

> *'go and do a day refresher...a lot of nurses do that all the time'.* (Int 13)

Another experienced nurse, who was one of the earliest respondents to qualify, echoed this view:

'I didn't do injections (during the training). But I did it when I needed to. I did extra training for that. But the extra training is just like senior nurse shows you how to do one, you do one, and it is the old thing of 'see one, do one, teach one' – so really, the whole thing and the fuss that was made about clinical skills I don't think needed to be made' (Int 16)

Extreme self doubt had been experienced by one person, who said she felt she did not know anything about anything when she qualified. However, she said she had very soon realised the opposite. This *eventual realisation* of the value of the training appeared to be a characteristic of the socialisation process and was expressed by five other respondents, one of whom had become a social worker. She said of the training:

'actually once you find your feet and get over that nervousness, and talking to friends who just did the DipSW, I think it was the same for them...but it wasn't until I was bit further in that I realised that it was like a jigsaw. The bits all came together at the end and when you found your feet you found a lot of stuff was coming back from uni that you had learned a long time ago and had filed away at the back of your head and had forgotten about'. (Int 16)

6.1.4 Identity and Values

Analysis of the interview data reveals that there were a range of dimensions to respondents' orientations towards practice. Foremost amongst themes which emerged was the importance of *direct work* with people as a part of the professional role. Eleven people mentioned this aspect. It was clear that for many respondents the nursing role was associated with more opportunity to do direct work, especially compared to the care management role. One nurse said of his decision to take up a nursing post:

'I liked the interaction. I thought there was a much better interaction with clients. I think the pressures in nursing are different to those in social work. There is less care management and purchasing of services. I can see the impact my input has on people' (Int 24)

For another respondent frustration with his job as a care manager was explained:

'I think we want to be more hands on. For example, I think even the people who work in the homes are surprised to see me throw the bag aside and sit beside the person instead of observing like a fool in the corner. I have no problems with that. That's the nursing side of me. The hands on, working with the person'. (Int 05)

The notion that this person has a 'nursing side' is an interesting one and shows again the duality of identity suggested by the survey responses.

Four people explicitly mentioned values as an influential part of their practice. One practising nurse believed she had a

> *'more confident set of values, understanding and articulate approach to tackling inequality than my peers and other nurses that I meet within the NHS'.* (Int 04)

She felt that this was one of the impacts of learning about anti-discriminatory practice on her course. A further respondent commented on the possibility that she might have chosen single training and said:

> *'if I had just done one route I would have done nursing and that was what I was looking into and it was a bonus that it was joint training. But I definitely think the values came in and really impacted on me and on my practice. That has probably taken me a lot further. It is such vague thing that you cannot really pinpoint exactly how it influences you but I really do think it has'.* (Int 18)

Another aspect to values which emerged from the data was the valuing of service users and putting them at the centre of the work. For one nurse this meant taking a person centred approach, which he defined as

> *'that ethos of putting the client and their support networks at the forefront'.* (Int 16)

A social worker valued learning to see the person first and the disability second. A nurse held strongly with the idea of the 'disabling society' and felt that person centredness came from social work not nursing, and that the latter was still characterised by a medical model. Another nurse observed that there was sometimes an 'us and them' culture between some nursing colleagues and service users, which he especially detected when he read comments about service users written by nurses in files. The social work aspect of the training was therefore attributed with developing respondents' critical thinking about structural discrimination (Thompson, 2006).

Other values embraced by a number of the respondents were those of teamwork and integrated working. Ten respondents made reference to the importance of these to their work, echoing the survey responses regarding teamwork. Three people perceived themselves to be good team players, one of whom had had very positive experience of working in a multidisciplinary team. A care manager reported that he related very well to the nurses in his team compared to other social workers, once again using the comparator of the singly trained practitioner to identify his own professional perspective:

> *'I don't see a barrier whereas other social workers can see barriers '.* (Int 05)

Another social worker attached such importance to involvement from other professionals that she would sometimes reschedule a multidisciplinary meeting if a particular professional could not attend, on the basis that responsibilities were shared and that to achieve the best outcome others had to be involved in collaboration.

Two of the most experienced respondents attached importance to being open to learning in teams and the fact that everyone has something to teach or learn from each other. One also felt able to be assertive when faced with some team members' reluctance to follow agreed plans:

> *'I think I feel relatively confident in getting a consensus on a care plan. I feel more able to identify and challenge members of the support network who may be trying to bluster their way into having their own say, when it does not appear to be what the consensus had identified as in the clients' best interests'.* (Int 12)

The other practitioner held a position of team manager in a multidisciplinary team and his perspective was that it was part of his role to assist partnership working by helping colleagues to cross boundaries. Being jointly trained had influenced this outlook. As a community nurse he had carried out a significant amount of joint work with Social Services Departments and had managed overlapping roles. He perceived collaboration as a learning process with some discomfort attached to it:

> *'All the time you are in your comfort zone you are less likely to learn, whereas if you are faced with those difficulties, you know, and quite often they are operational logistical difficulties, you have to try and manage.....once you*

become qualified it is a real mistake to retreat into the comfy arms of those professional bodies'. *(Int 23)*

It is clear from the data discussed so far that respondents located their identity more in the role they carried out than in the training, which had not fully prepared them in some aspects of practice or for the fact that there were no roles in which to practise jointly. Importantly, however, they retained an aspiration to use the breadth of skills they had although the name commonly given to their identity (joint practitioner) begins to appear misrepresentative of the reality of their working practices.

6.2 Holistic Practice

6.2.1 Breadth of Perspective

The importance attached to *breadth of knowledge* by respondents in the survey continued to emerge as a feature of respondents' professionalism in the interviews. It also appeared to be the rationale for claiming to have a 'bigger 'or 'wider' picture which made respondents' practice more holistic. Such terms were used by four respondents in the interviews. One observed that the health and social perspectives were

'drummed into us throughout the course. In the end it is just conditioning. You come out with this mantra, social and health, and you find yourself thinking in that way and don't forget the other bit'. *(Int 11)*

For one person practising as a care manager, the advantage of joint training lay in knowing about all those things which were not usually in a social work course. He gave examples of knowledge which he felt made his practice more effective. This included knowledge of primary healthcare, tertiary health, complex health needs, health promotion and clinical governance. These were what made him an

'all rounded practitioner' *(Int 07)*

and able to apply his practice in a more comprehensive way.

For a CAMH practitioner the knowledge of what was available in the voluntary and independent sectors was also a part of seeing the bigger picture. Joint training had brought an element of creativity to his practice through increasing his knowledge of different services which could be accessed. He commented:

> *'I think it allows you to see beyond service constraints'.* (Int 15)

He and a nurse practitioner both felt that the nursing side of their studies had given them a bigger evidence base for their practice. Two other nurse practitioners said they valued the *scientific* knowledge which nursing brought to their practice. One of these summarised this as follows:

> *'I found it interesting and I think it gave me another outlook, and I think as a social worker I could talk about people's quality of lives, and possibly win or lose that argument on purely values, depending on whether the person I am speaking to is going to share that value, whereas if I can show someone a chart or a graph or data I might be able to win that argument a bit better. Its does seem to have more clout. This is a bit of science!'* (Int 08)

This respondent said his job description expected him to work within a bio psycho social model of care, a model strongly associated with nursing. This quotation also suggests a 'complementary' effect of nursing and social work when brought together into one overall perspective.

6.2.2 Using the Alternate Discipline

Although there was a strong theme emerging from the data about being unable to practise jointly in both professions simultaneously, evidence emerged that in their singular professional roles practitioners were using knowledge and skills associated with their alternate discipline (defined here as the profession they were *not employed* in).

It was interesting that most interview respondents found it difficult to differentiate between the skills of nursing and social work when asked to consider a situation in which they might have used both. Seven people felt that differentiation was difficult because of the crossover or overlap between skills. Another person put it succinctly:

'the skills blur'. (Int 25)

However, in response to this question sixteen people gave examples of practice where they believed they had used the combined skills of nursing and social work. Eight believed that both sets of skills were particularly relevant in assessment, reflecting similar findings at the survey stage. Three people felt that the experience of the alternate discipline had given them an extra dimension of awareness which impacted *unavoidably* on their practice. One social worker commented:

> *'It's difficult to go and do a community care assessment on somebody and not actually be aware of what health issues they have, so it's always there....because we were constantly taught during the training that when you are doing assessments you don't just think social care assessments but do health care assessments at the time'. (Int 02)*

A primary mental health practitioner who identified mainly with nursing highlighted the influence of social work on the way she practised:

> *'It is having that knowledge that you can't forget. It's like a nurse not knowing what social work core competence is and the values of social work practice. Although I am operating in a health setting I do bear in mind those core competencies and those values'. (Int 14)*

Further analysis revealed that for many practitioners aspects of the alternate discipline appeared embedded in their practice, rendering this unavoidably holistic in character. As identified in the survey, this gave rise to tensions for some social workers, particularly those employed as care managers, for whom the health dimension was only acknowledged as a minimal part of their role or wasn't acknowledged at all.

6.2.3 Social Workers Using Nursing Skills

Interviews with those respondents who had experienced employment in social work or care management roles since qualifying (n=15), including one person who was a training manager, revealed that in all cases there was a perception that they were using aspects of their nursing skills in their current work. The most frequent activity referred to was that of *assessment*, where eight people identified that they used skills from nursing in this process, especially when completing assessment forms. The evidence which emerges from the data is that these practitioners believed they were

doing a more in depth assessment of health issues than singly trained social workers were normally required to do. One person said:

> *'I think I am more holistic, yeah.....definitely more holistic. We have assessment tools which guide us in what we do, but you get to the end of them. But I think further than what is on the assessment for the social care...I think about people's health needs'.* *(Int 02)*

This emphasis on health was echoed by another social worker, whose assessments were influenced by that

> *'background health knowledge and being aware of it as well, so it doesn't just become another box to be filled in. To me it is an important area that has to be looked into....if I am doing an assessment I won't just write what the condition is, I will make sure I include within it what that means, and it is not good enough just to write it, somebody actually needs to understand'.* *(Int 19)*

A second area in which respondents felt their nursing skills were being applied was that of *health surveillance or promotion.* Two social workers perceived that they were involved in this. A social worker employed in a community learning disability team gave an example of how she monitored clients' medication when she visited them, reminding them of its importance. She referred to one case in which she found a client had not taken his medication for several weeks and had become depressed. As a consequence she established more regular visits until he was able to be monitored through a care package which she put in place.

Another social worker in a homeshare service for adults with learning disabilities described how she monitored the health of a client with dementia in partnership with the client's own social worker. A third respondent summarised his experience of monitoring:

> *'I have been able to look at areas around how people managed their medication and the kind of impact of not having medication on people who have been affected by their epilepsy so that would have had an impact on their behaviour.....you know social work colleagues wouldn't have known there was a partial seizure going on'.* *(Int 07)*

Four social workers referred to their use of medical or health *knowledge* in their practice, one of whom cited his knowledge of syndromes as important to his practice.

Two social workers were using their knowledge for health promotion activities. One described how she had provided information to a service user of the dangers of drinking and smoking excessively. She felt that social workers would normally have handed this over to the health professionals from the multidisciplinary team, but it was 'natural' for her to do it.

This suggests that health promotion was an embedded aspect of her professional identity. She had also trained carers in respect of health promotion. This is not a subject that is taught in any depth on social work programmes so it is unlikely that a singly trained social worker would incorporate this so naturally into their practice.

6.2.4 Nurses Using Social Work Skills

To explore this dimension the transcripts of all those respondents who had worked as nurses at some point in time since qualifying (n=12) were analysed. Six respondents believed their ability to make referrals to other professionals was derived from the social work aspects of their training. This was linked to a *knowledge of networks* within which referrals could be made. For one nurse practitioner this was about knowing who should be in place to support a client and when. Another nurse based in a community learning disability team explained:

> *'I have recognised that I am employed as a nurse and what my boundaries are, and my role, but I am able to identify other issues that I can find other people to help with. I think I must make more referrals than anybody. I am always referring people to things, to Social Services, to other health professionals, to whoever I think is appropriate'.* *(Int 16)*

This suggests a proactively inter-professional approach to practice. In a similar way, another nurse working in an exclusively NHS learning disability team recounted how he had brought local care managers into the nurses' meetings for the first time:

> *'I got social services to come and sit in the meetings and that worked really well, so we were already joint working and integrated before we were told to integrate. I initiated that, and that was because of the joint training I think'.* *(Int 25)*

He felt that this led to a more relaxed working atmosphere and that this benefited work with service users because people got to know the colleagues they needed to liaise with personally.

Another area of influence from the social work side of the training was *communication*, acknowledged by six nurses. Two of them said that building relationships was a key area of skill in their practice. One explicitly linked this to social work:

> *'If I think about going to visit families then sometimes you make a relationship with a family where previously that hasn't been possible and you do that by spending time with them and by letting them tell their story and for some families even though the parents are quite elderly this is the first time that has happened and that is a combination of both sets of skills definitely...listening, empathising, counselling type skills...and rather than this I think nurses have tendency to want to get on with their jobs'.* (Int 04)

This reminds us of differential task and relationship orientations found by Russell and Hymans (1999) in their research with nurses and social workers discussed in chapter two.

Another nurse practitioner working in the field of challenging behaviour referred to having to get people on his side and show them that he could make their life better. He described this as social work approach. He cited an example whereby he felt that he had managed to gain the trust of parents by building a relationship and had got them to engage with social services where previously they were very distrustful and even hostile. He felt the training had given him insight into social needs.

Five nurses alluded in different ways to an understanding of *social context* as a feature of their practice influenced by social work. For one nurse, context related to parental functioning and consequent risk to the children in a case that was being jointly worked with social services. The social worker with whom the nurse was working had concluded that the children's behaviour was the problem, but the respondent observed that the parents' behaviour was creating very poor conditions in the home. The context was of such concern that the respondent felt she had to report the matter formally to the social services department.

The respondent cited above also perceived the impact of her awareness of social need and context to her approach to health care:

> *'In every assessment I undertake, understanding someone's social circumstances and the impact of that on their health makes a significant difference in the kind of care plan that I am likely to come up with and I might start by referring to social agencies or trying to change someone's housing before going and doing one to one work with them around their health needs. Because it seems to me that if you haven't got the fundamentals right you are not going to make a huge impact on the rest of someone's life'.* (Int 04)

This example reminds us of the large number of survey respondents who felt that their perspective was broader as a result of joint training and suggests a justification for using the word *holistic* to describe the approach to practice. Three other nurses felt they had derived a similar awareness of context from the training, one of whom captured the essence of this:

> *'Maybe if you were just doing the nursing you would think more narrowly around someone's health needs, whereas having both the trainings you think more of the person as a whole and the background that they come from'.* (Int 18)

For two other nurses, *context* was linked to political ideas and values which they had gained from the social work element of their training. One referred to a commitment to justice, derived from the anti-discriminatory practice studied on the course, and the other noted the influence of the social model of disability and knowledge of how society disables people:

> *'I think that is where social work informs your practice, because you are more person centred and you value the individual more. You start where they are, more so than I think you would if you were purely nurse trained'.* (Int 25)

This nurse summed up his view on the influence the social work element of training had brought to his practice:

> *'I do think that my understanding of need and how it is assessed and my insight into people has been enhanced by the social work training. So I would say I am a bit of an enhanced nurse. A social work enhanced nurse'.* (Int 25)

The final aspect of the nurses' practice which appeared to be influenced by social work related to *assessment*. Four nurses referred to this in different ways in

interviews. One described how a knowledge of social services and their policy on community care assessment could be used to clients' advantage. As a nurse he could prompt the client to request an assessment, thereby ensuring they got one as this became a statutory duty to provide, once requested by the client.

6.2.5 Boundaried Practices

Examples in the previous two sections clearly suggest that practitioners working on either side of the divide between health and social care perceived they had used some of the skills and knowledge derived from their alternate discipline. Respondents practising as social workers were conscious that a key difference between what they could do in a social work role and what only practising nurses could do related to degree of intervention. Active use of the 'nursing' skills and knowledge in *assessment* appeared less likely to compromise their professional social work role than carrying out 'clinical' tasks. However, even in respect of assessment, there were restrictions placed on practice, where use of health knowledge was controlled or discouraged.

One example was reported by a social worker who had taken up a post in a hospital discharge team after completing her training. She had found that there was great opportunity to use her nursing knowledge there, but had to be judicious about her assessments for 'political' reasons:

> *'For one of the first assessments I did at the hospital social work team I included all sorts of health issues in it. The team manager put a line through much of this, saying I could not identify so many needs - the local authority would not be able to meet them. I had to be really careful with what I identified as a need'.* (Int 09)

A similar 'reporting dilemma' arose for a social worker working in child protection when she prepared a report on a child aged 14 who was beginning to drink heavily, as his father had done. This respondent had put detail in her report about the physical effects on the child's body of drinking at his young age. She was advised to take this out and ask a nurse who was involved to put it in *her* report instead.

A third respondent had also experienced restrictions on her assessment activity. This resulted from the fact that she worked as a social worker in a team where there were learning disability nurses employed. Her role involved ensuring assessments were

done on clients in transition from one service to another. When she took up her post she began by carrying out initial assessments on her own, but paradoxically was advised to practise differently:

> *'I was told by the social worker that I always have to have nurse present...and I thought – I can do this! It's no big deal. I can ask these questions and I can make a referral to the psychiatrist. No you can't do it, said the social worker'.* (Int 06)

The policy and practice in that team was for a nurse to accompany the social worker to the initial assessment. The respondent felt that this was something she would like to do by herself and was competent to do so and it was a waste of resources. Additionally this meant a delay for the client, as nurses were not easily available to attend.

The feeling of being 'boundaried' by singularity of role was expressed by another respondent. Employed as a care manager in a community learning disability team, he felt his contribution was constrained because of the role care managers occupied, which he described as 'bureaucratic' and detached from direct work:

> *'I didn't feel prepared for the care management side of it...on the nursing side, as I said, sometimes you are standing there and you can think of ten better interventions or you do want to be hands on but you can't because you are aware of the line you are overstepping. You are boundaried'.* (Int 05)

Two *nurses* also cited examples of where boundaries were present but could have been constructively crossed. One respondent worked in an NHS Drug Detoxification Centre and remarked that he had to refer clients for a community care assessment so that they could access support after their period in the Centre. He felt frustration at the very long wait clients experienced before the social worker had time to visit to do the assessment, which he felt he could have done.

The other nurse, employed as a behavioural therapist in an NHS multidisciplinary team, had made referrals directly to other professionals without going through a social worker. He commented that there was:

'Pressure to stay within your professional parameter and to not do anything that could be deemed anyone else's responsibility. So I have actually sometimes been told off for acting too much like a social worker – that's a social worker's role! Why did you make that referral? The social worker should have made it. And I say –well, it is a piece of paper half a page long, it takes two and a half minutes and I have the link!'. (Int 08)

This practitioner felt that pressure came from waiting lists, combined with a perception that senior managers did not really believe in multidisciplinary working but were just doing it because they had been told to. Wall (2003) asserts that ethical interprofessional working requires professionals to fulfil their purpose by using *all* their expertise in the patient's interests. There was clearly a sense of conflict here for jointly trained practitioners.

6.2.6 Pushing at the Boundaries

In contrast to the preceding examples, four social workers reported situations where they felt that they had been allowed to cross boundaries and where there had been some positive outcomes. This suggests that role flexibility can depend on the culture of particular teams or orientations of particular managers, and is not just driven by policy. One social worker identified a situation in her current employment as a care manager where she was looking at the health needs of a client and coordinating a number of professionals in respect of this, work that would normally be done by a nurse. Her team had accepted she lead the work because she knew the client very well.

Two other social workers both reported situations where they had undertaken tasks normally carried out by nurses because senior staff had requested this as nursing staff were not available. One had carried out a visit with another social worker to a care home for a potential client to evaluate its likely effectiveness. The other had been asked by a psychiatrist to monitor the health of a client just discharged from hospital under the Care Programme Approach. The client should have been allocated a nurse but as none was available the respondent was asked to carry out both roles.

6.3 Interprofessional Competence

One of the key themes to emerge from the interview data was a sense of the interprofessional competence of the practitioners. In chapter five the survey data revealed the characteristic duality which framed respondents' perceptions of their knowledge and skills. The interview stage revealed more information about what this duality meant in practical terms. Four identifiable features of this duality emerged from practitioners' talk. These were networking and communication, transcultural understanding, confidence and assertiveness.

6.3.1 Networking and Communication

In an earlier section (6.2.4 above) knowledge of networks was identified by nurses as complementary to their nursing practice. Other respondents also felt that their training had given them the ability to network and gain access to those who could meet the clients' needs when this required resources beyond the scope of their own particular competence. These respondents felt that joint training had given them the skills to interface widely with other practitioners and to know not just who to refer on to but also how to make the referrals in order to get needs met.

Two practitioners described how they felt their training had given them the capacity to carry out an *interpreting* role between other professionals and clients or their families. This was necessary when other practitioners used jargon that was inaccessible to clients or their carers. Both practitioners were employed as social workers in Disability teams and they felt their training had given them the ability to further explain matters when relatives had questions or doubts. This saved having to make another time consuming referral to the nurse. It could also alleviate the burden to the family of having to tell their story too many times. One reported:

> *'You are talking to families about gastrostomy tubes and you can actually appreciate the medical side of that without them having to explain to you every little thing about it, cos families have to explain everything enough times without having to go through it again and again and again. I hope families have found that'.* *(Int 09)*

A nurse practitioner appeared to have taken a very similar (although seemingly unapproved) role when he described how he had built a relationship with a family who were anxious about social services and scared of the social worker's power:

'Sometimes I have been the only person for a while that the family is willing to engage with, and I have been able to bring in the other bods (professionals) slowly..... ....I think I have been able to, in a way, just kind of move between these.. which although I think has been useful for families, useful for social workers, useful for health practitioners, is not always welcome from the health service'. *(Int 08)*

Both these examples suggest practitioners were taking an intermediary role where the network was at risk of disempowering or excluding service users. They provided a source of communication to maintain appropriate contact.

6.3.2 Transcultural Understanding

Continuing the theme of communication, the data revealed that practitioners felt they had an understanding of the two cultures of social work and nursing and the skills associated with working (and moving) between them. Six respondents made reference to the perceived advantage of understanding the language, jargon or terminology associated with both cultures. This links to the *breadth of knowledge* that many of the survey respondents had mentioned in the survey, reported in chapter five. One nurse practitioner, now employed as a manager of a multidisciplinary team, acknowledged the importance of language, but this was linked to a broader understanding:

'Language, understanding different perspectives, you know. Again it is that broadness, recognising professional issues I suppose, recognising the issues that are attached to being a professional and being able to transfer from one professional group to another....communication, all sorts really, recognising shared values and being able to help other people recognise that and work in partnership.' *(Int 23)*

Another practitioner working as a social worker in a Disability team described how she ran a 'drop in' for clients at a Child Development Centre once a week, based there with health professionals from different disciplines. She believed the fact that she was nurse trained gave her a good relationship with the nurses there because she could talk the two languages:

'When they do a multi-agency assessment of a family of a child and they feed back to the family they call it a case conference, but obviously within social services a case conference is a child protection matter, so they have different language and different things mean different things within their role – so working across the

two you can put people's minds at ease because you understand the language that they are on about and talk in terms that they are comfortable with' (Int 20)

Two other practitioners said they felt 'comfortable' working with other professionals and a third, who had held posts in both nursing and social work since qualifying, said he felt very comfortable in either job and very confident in his skills. Six respondents reported that good relationships were a feature of their practice, three of whom were practising social workers and who specifically referred to their working relationships with nurses.

One of the foundations of these positive relationships appeared to be the presence of *empathy* by the jointly trained practitioner towards practitioners of other disciplines. Five people (four social workers and one nurse) made reference to their understanding of the perspectives of other professionals. The social workers referred explicitly to their understanding of nurses, of what they do and

'where they are coming from'. (Int 02)

One social worker said that her knowledge of how hospitals operate from the inside (through her placement experience) had given her much greater understanding of resource constraints and a consequent

'empathy for different services' (Int 13)

For the nurse practitioner, his cultural understanding was once again linked to the broad perspective resulting from the training and

'being able to recognise and see that different people might look at it (practice) slightly differently and you need to take that into account and work with that, not try to resist it or defend against it or kick against it really'. (Int 23)

Another foundation for this empathy may have been knowledge of other practitioners' roles, identified by six respondents as a feature of their understanding. There was a link made by these respondents between having the knowledge but also the good relationships needed for getting the 'right' people involved who could assist your client. For a respondent employed as a Training Manager this was part of

'looking at it from both sides and drawing in other professionals and knowing what they can do and knowing the kind of assessments they might use'. (Int 10)

She felt this knowledge could be passed on to teams and to service users so that they could also be aware of the potential of others to contribute to care.

6.3.3 Confidence

Some respondents felt the training had contributed towards confidence building. Seven people specifically referred to this during the interviews. It may be that this confidence gave people the self assurance to practise without a purely defined identity.

Two respondents felt they had the confidence of more knowledge, one of whom cited the influence of the diversity of her placement experiences during the training. A third said that whilst he had to recognise there may be gaps in his knowledge there was also a confidence in knowing what he could contribute and from the fact that that joint training

'gives you an edge over singly trained practitioners'. (Int 15)

This practitioner referred to a *loss of deference,* one aspect of the new professional context identified in chapter three. The respondent discussed what he considered to be a traditional hierarchy of roles within nursing and believed that difference in status between nurses of different grades was a characteristic of NHS culture. He felt the joint training challenged this deference and gave practitioners another perspective:

'we don't go in with that preconception that there is the status and you are expected to bow down to it'. (Int 15)

Another respondent talked about the confidence of being able to talk to people in senior positions on an equal footing, whereas before the training he would not have been able to do this.

6.3.4 Assertiveness

Respondents' talk about their experiences revealed several examples of assertiveness. In nineteen of the interviews, respondents talked about situations or events which in greater or lesser ways indicated this characteristic. Assertive actions included those on a relatively limited scale, exemplified by two respondents who at job interviews had argued that their combined skills would make them very suitable applicants, one of whom negotiated to start at a higher point on the salary scale.

At the other extreme, two respondents had made complaints about the behaviour of other practitioners where this jeopardised the wellbeing of service users. One complaint had concerned the observed misuse of medication by agency staff in a residential establishment. The other was about the conduct of staff who regularly argued in front of a disabled service user about whose job it was to help her access the transport provided to her. The latter involved the jointly trained practitioner in devising new guidelines for staff in order to implement a more professional approach.

Another respondent working as a social worker had challenged a consultant psychiatrist's decision to prescribe a particular medication to a service user without bringing this to a multidisciplinary forum to discuss the person's best interests (in the absence of their capacity to consent). This had led to a 'counter complaint' to her own manager about her challenge. The practitioner was critical of the consultant's autocratic approach, which she did not perceive to be in the client's best interests.

It must be acknowledged that a characteristic such as assertiveness is difficult to attribute to the influence of joint training. It was, however, a noticeable element arising from respondents' talk. The ability to challenge other members of the multidisciplinary team was not a topic on the interview schedule but it was clearly demonstrated in examples of practice which emerged, suggesting this may be a part of their 'interprofessional competence'.

6.3.5 Inter- professional activities

Not surprisingly, considering the survey results, examples were given by interview respondents of where they had in some way worked along or across boundaries. In a number of cases this had involved working in partnership. Some examples were as

follows: a nurse practitioner had written joint letters with social workers to a Housing Department seeking accommodation for clients; another nurse had intentionally written reports about clients in a way that he knew care managers could use most effectively to secure resources; a social work practitioner working in a child protection team had taken allocation of the health and disability cases; and finally, a care manager had successfully secured a £180,000 per year care package for a client with autism in a care home that was closing down. His manager had asked him to take on this case because of his health knowledge. The funding had come from the NHS.

6.4 Boundary Talk

In their talk, respondents expressed ideas and personal theories about inter-professional work and the relative roles, positions and working practices of the two professional groups at the heart of joint training. This constituted a *critique of observed practice*. Exploring this theme can give us insight into the influence of the training on the outlook or 'philosophy' of jointly trained practitioners. What is perhaps exposed here is the nature of the *crucial space* which Bernstein (2000) said separated disciplines and strengthened their separate discourses and voices. The space at the boundaries where there is an indefinable overlap. As in the case of the survey data, interview respondents frequently made comparisons with singly trained practitioners, not in such a way as to express superiority but certainly in terms of advantage and difference. This section focuses on what respondents said about practice they had observed and the views they held about this.

6.4.1 On the Image of Social Work and the Role of Care Managers

Seven respondents perceived the image of social work to be problematic, three of whom had practised in both nursing and social work since qualifying. Two said they did not refer to themselves as social workers, preferring to say that they were a nurse or worked with children with disabilities. This was especially the case when talking to people with learning disabilities, as one related,

> *'because on the odd occasion when I have said that I am also qualified as a social worker they say – no you are not a social worker! Oh my God! I hate social workers!'* *(Int 18)*

This negative public perception of social work appeared to be paralleled by a negative professional perception regarding the role of care managers. Eleven respondents made comments about the care manager role, which was clearly negatively viewed. Two people working as care managers lamented the fact that they could not do direct work with clients. It was a role which focussed on assessment and purchasing services. It was seen by other respondents to involve too much administrative work and there was a problem of lack of resources in social services departments. One commented:

> *'I want to be the person who is enabling and helping people, as opposed to me saying, no I am sorry we can't afford this'* *(Int 06)*

Whilst this was not seen as a problem for all care managers, the limited scope to do direct work was unappealing. One social worker commented:

> *'I think probably I have been fairly lucky in the sense that I am not a care manager so there is more capacity for me to work directly with the service users'* *(Int 01)*

Two respondents (one a care manager and one a social worker) indicated that they believed that nursing was the role associated with *intervention* and social work and care management less so, the latter having a focus on assessment, evaluation and review. Paradoxically, one social worker, who had also practised as nurse, felt that it was nurses who did the social work. He described this part of a nurse's role as

> *'old school social work'.* *(Int 12)*

A nurse practitioner echoed this viewpoint when he described care managers as

> *'an unhappy bunch, stripped of their therapeutic value'.* *(Int 25)*

Another nurse underlined this paradox:

> *'I can see care managers are having to be gatekeepers, so the people who are advocating for the clients very often and actually doing the real social work are the nurses'.* *(Int 16)*

Both of these respondents said they liked working for the NHS because it was free at the point of delivery and because as nurses they were providing the service itself and were able to do an assessment without this being

> *'tainted or tarnished by the resources I thought were available from the council'.* *(Int 25)*

As nurses, they believed that they possessed more professional autonomy than care managers. This interest in direct work may be one of the reasons why a number of respondents were actively looking for nursing posts, which were not easy to find in the community setting. It was clearly one of the reasons why another practitioner employed as a social worker was planning to move back into nursing:

> *'Because as a nurse you are the service. You are the resource and as a social worker you are signposting and you are assessing for the resource[...]so I think in my heart I am a nurse'.* *(Int 20)*

6.4.2 On Interprofessional Relationships

Respondents observed that these were not always very constructive. Four people referred to *defensiveness* or *preciousness* in other professionals' behaviour, with an implication that this was not an aspect of behaviour in which they themselves engaged because of the dual perspective they held and the particular nature and socialisation of their training. One of the social worker respondents had noticed that some colleagues who were singly social work trained had very poor relationships with their health colleagues. She commented:

> *'I have tried to work out why that is and I think it has got something to do with just being quite defensive in your role, you know, and with being quite blinkered about your role and having barriers and remits whereby you know they haven't quite had the training to know how to work in partnership. And they are always blaming the health professionals.....and not looking at their own mindset or outlook'* *(Int 01)*

A nurse practitioner reported a corresponding attitude in some nurse colleagues towards social workers, who were sometimes suspicious that the social workers were out to make them look silly:

'When you are on their territory there is an us and them sort of thing...which there really isn't...but all it takes is for a couple of social workers and the nurse involved to be slightly insecure and that sort of thing does happen'. (Int 12)

As discussed in chapter five, jointly trained practitioners had experienced defensive attitudes towards themselves. One nurse described how some traditionally trained nurses would seek to find out how much he knew about a particular 'obscure' syndrome. Another recounted how in a local nursing forum a singly trained learning disability nurse opposed to joint training had praised the closure of the local joint training programme. Hugman (2003) observes that interprofessionalism can be perceived as dangerous because it introduces ambiguity and threatens the existing order. These examples may be reactions to feeling threatened.

A social worker explained the paradoxical mixture of empathy and conflict that went together when you were jointly trained:

'it can be quite difficult cos they (the nurses) will be arguing for why something should be happening and I can understand that from the medical model that they are using that that's what they feel should be done, but at the same time I am not employed to work to that model. I am employed to work to the social model'. (Int 19)

She recognised with some irony that had she taken a different career path she might have been in the same place as the nurses and found it difficult to understand why a social worker could not support their perspective. This provides a good example of the potential depth of the professional empathy discussed earlier in this chapter (see section 6.3.2).

Another social worker identified the 'fear of the unknown' that exists in both social workers and nurses when they do not fully understand what the other does. He felt that this was where being jointly trained was very helpful as sharing a qualification with people put them at their ease. A nurse felt that in his role as deputy manager of a multidisciplinary learning disability team he sought to develop the idea of *sharing* skills:

'Most of my work has been around encouraging the sharing of skills rather than the ownership of skills and I think at times professional identity relates to ownership rather than sharing' (Int 23)

6.4.3 On Single Training and Joint Training

During interviews specific reflections on learning disability nursing were made by eight respondents and focused on the clinical aspect of the role. Three people (two nurses and one social worker) felt that the learning disability nursing role was less 'clinical' than in other branches of nursing. A fourth respondent, however, felt that singly trained learning disability nurses would generally know more about physical signs and symptoms than a jointly trained person. This could give them an advantage, although not always so. A nurse manager said that the joint training did not necessarily give the depth of knowledge, but it was counterbalanced by developing flexibility. She compared herself with singly trained nurses she managed:

> *'I think in work you relax into being comfortable with – 'well, I don't know that, but I either know someone that does or I can go and find that out quite easily' – whereas a traditionally trained person might know every aspect of diabetes like the back of their hand but might be missing the social factors that are contributing to someone not cooperating with a new diet for example'.*
> *(Int 04)*

For this respondent, an important feature of practice was knowing what you know and don't know and therefore what you need to find out. It was not necessary to have all the detailed clinical knowledge of a singly trained person but you must be able to develop the knowledge as required.

Comparisons with singly trained social workers revealed the influence of the *specialist* nature of joint training. Four respondents observed that social workers did not always have the specialist in depth knowledge about disability which could fully inform their practice and had not had training in health. One referred to social workers' lack of experience of learning disability and the fact that some had not heard of the Valuing People White Paper and consequently did not know what support was available to disabled children.

Two graduates from different universities referred to their perception that some singly trained professionals would try to work on their own with a client without referring on to others who could help and possibly offer more long term solutions. A nurse suggested it was part of the ethos of nursing to look to your own resources and increase your own capacity before acknowledging you cannot provide the solution.

He had observed singly trained practitioners who only referred on to others as a *last resort*. In his own practice, he tried to decide from the start of a case who were the most appropriate people to take it forward, based on what the key issues were. He attributed this search for wider solutions as an influence of his joint training. In a similar vein, a nurse who managed singly trained learning disability nurses as a part of her role suggested that some nurses were blinkered in their approach:

> *'they would see someone who might be unfit and overweight and would instantly think – I can correct that. I can get them in the gym and can tell them what healthy eating is and I will go away and come back six weeks later and they will be thin...and actually life isn't like that and there are some clients who have horrendous health needs but I know I can't make a difference on my own, and unless their social circumstances change here is no point in even attempting to address these things because they are not on the client's radar. (For me) that understanding is much more entrenched and its like a house built on rocks rather than sand'.* *(Int 04)*

This seems to be an example of looking at the 'bigger picture' which many practitioners have referred to in other parts of this analysis. It suggests that joint training may develop a collaborative insight and an awareness of the interdependence of health and social factors in people's lives.

6.4.4 On the Value of One Practitioner

What may be emerging through these practitioners' comparative analyses are characteristics of an *ideal type* of professional orientation. This combines an inter-professional competence with specialist knowledge resulting in an outlook which favours collaborative action and problem solving and goes beyond individual practitioners being able to provide all the solutions. It also, however, incorporates the possibility that *in some circumstances* one practitioner could alleviate the disadvantage of a series of multi-professional contacts with clients.

Seven respondents mentioned the value of this idea. The benefits were seen as efficiency, avoidance of duplication, reduction of distress to the client (because less individuals were involved) and the advantage of improved continuity in the work. One person cited a very complex case he encountered when working as a community nurse. Here he felt he had used his whole range of skills without the client having to build up trust with a number of different professionals and manage the complexity of

that. This case may be illustrative of the potential of a holistic approach when traditional, separate service responses are replaced by something more creative. He felt this case was one of his successes. His description of the case is reproduced in an excerpt from the interview (see appendix 8). The case summary demonstrates a jointly trained practitioner acting as the lead practitioner, not to the exclusion of other professionals but apparently to the benefit of a sensitive and vulnerable client. The case reveals the potential implications of missing vital knowledge about a situation where services and professionals work in singular ways informed by singular perspectives. Here the practitioner with a broader overview and extended role appears to have been able to make a difference.

6.5 Placement Influences

During the interviews almost all the respondents (n=22) made reference to the placements which they had undertaken during their training. These had an influence on their learning or their practice in different ways. Nine people spoke positively about the *variety* of placements they had had and how these had enabled them to learn a wide range of skills but also develop the understanding of different cultures referred to earlier. One person's view captured the diversity of the experience of jointly qualifying graduates:

> *'I think the placements also helped. I mean I did two placements in hospitals, one in a mental health residential home, one in a learning disability day centre, and again, you experience different cultures'.* *(Int 04)*

Another respondent described the diversity of placements as

> *'a solid learning platform'.* *(Int 07)*

Placements in multidisciplinary teams appeared to have been particularly influential for a number of respondents. Eight people referred to this. Such placements led to meeting and mixing with a range of other professionals and an understanding of what other professionals did. One respondent referred to the positive outcomes from this:

> *'mixing in different places makes you very comfortable with some of the things other professionals are saying and you have a vast experience.....dealing with clients'.* *(Int 06)*

Not all placement experiences had a positive influence, however. Eleven respondents referred to negative placement experiences they had had during their courses. These included the experience of placement breakdown, something that had happened to two students (one based in a social work team and one in a nursing team). Both appeared to be connected to lack of support.

Additionally, six respondents expressed dissatisfaction about the *balance* of placements they had been allocated whilst in training. Two were concerned that they had not had sufficient placement activity in the social work discipline and two in the nursing discipline.

These responses suggest a particular issue for joint training programmes, namely the question of achieving a balance between the two disciplines that leads to students being confident that they have a sufficient knowledge and skills base in both. Both the survey and interview data suggest that this balance is difficult to achieve. The balance may be equally difficult to define. Given that the nature of placements on joint training programmes is inevitably varied and influenced by local services and availability, each individual's experience of the training will vary too. Students undergoing this type of training are required to assimilate two professions at the same time whilst having quite different learning pathways depending on the placements that were found for them. From the data it appears that degrees of assimilation will vary in these circumstances. With varied degrees of assimilation, qualitatively different shades of professional identity may emerge.

Eight respondents said their placements had had an influence on their subsequent employment. Two people had had negative experiences on Adult Nursing placements early in the training and this appeared to have played a part in confirming their career path into more social work oriented posts. One said:

> *'the placements I enjoyed were much more on the social side, rather than the placements in the hospital which I hated.....I didn't like and I still don't like the intense medical model that nurses use'.* *(Int 10)*

This links to ideas discussed in chapter three about the process of professional socialisation, which has been said to begin *before* professional training begins. Some

respondents may have had a predilection for one discipline or the other. Experiences on the programme could play a part in confirming or disconfirming their initial orientation.

There was a view expressed by two people that placements on a joint programme were *very* influential in taking students forward in a particular career direction. One respondent spoke from the experience of having supervised jointly qualified students on placement. He felt that

> *'primarily depending on the last piece of work you did or the last placement you did you feel that you are very much in that kind of mould'.* (Int 07)

Although this respondent felt that he was a 'nurse' at the end of his training because his last placement was a nursing one, ironically he went into care management. Whilst this appears to be contradictory, it is perhaps an indication of the ambiguity of identity for these practitioners and how much this identity is a personal construct as well as a professional one.

Overall, the data suggests that exposure to a range of settings may be one of the reasons why such a large number of survey respondents believed that they were well prepared for dealing with inter-professional issues.

6.6 Conclusion

In this chapter the data from the interview stage of the research have been presented, analysed and explored with reference back to the survey data where appropriate, noting areas where triangulation between the two data sources occurs. In the next chapter there will be a discussion of these findings to develop the process of theorisation from the data.

CHAPTER SEVEN

Discussion of Findings

7.0 Introduction

This chapter will focus on a discussion of the findings of the research by relating these to aspects of the literature and theory which were explored in respect of inter-professional education and professionalism. The chapter will consider the findings emerging from the study in line with the three research sub-questions. These dimensions concern the influence of joint training on practitioners' construction of their professional identity, on their skills and on their practice. Additionally, the chapter will analyse the positioning of graduates in the new professional space that they appear to occupy. The findings will then be used as the basis for developing a theoretical position on the influence of joint training in the concluding chapter of the thesis.

7.1 Constructing Professional Identity

The difficulty of defining professional identity was discussed in chapter three, where it was noted that this is a socially constructed phenomenon. Hall (2000) suggested professionals may derive their identity from association with a group or with an ideal. The fact that a third of survey respondents ascribed their identity to the category of 'joint practitioner' suggests that there was a wish by some people to be associated with this ideal type of professional. However, in the interviews only two respondents used this term actively to define themselves. The majority of interview respondents associated their professional identity with the role they were employed to perform, although some appeared to use this as a badge of convenience whilst aspiring to a role they could not carry out.

Professional identity was therefore a concern for some respondents because they aspired to use all of their skills and were disappointed that no posts were available to facilitate this. Their training had not impaired their understanding of professional accountability as there was a noticeable absence of role confusion. Neither did *role*

ambiguity feature prominently as a concern. What is distinctive about these practitioners is that, once qualified, their professional identity had to be located in their job role rather than their sharing of a common training, as very few had any significant contact with other people who were jointly trained. There was therefore a conflict between the assumed identity (forced into singularity of role) and the *internal* joint identity aspired to. The aspiration itself distinguishes these practitioners and makes dissonance a feature of their identity. They *expected* to be able to use their skills upon qualification and continued to believe that this was what they had trained for.

Although the term *joint practitioner* had been used with many of the students during their training and was a language clearly understood in interviews, the data revealed that respondents were being trained for a role that did not exist. During the research this term began to lose its power for myself, as researcher. The interview respondents revealed they could not carry out such a role, and one in particular referred to the term as a 'misnomer', preferring to be known as a jointly *qualified* practitioner. In a Bernsteinian analysis, the term 'joint practitioner' belongs to the concept of 'framing'. It is a term created by educators to define their progeny and a powerful socialisation device. It is not a term which is current in practice. It seeks to describe a practitioner who it is hoped will promote or embody a thus far, undefined discourse. The unnamed discourse appeared to be problematic for some respondents, illustrated by their concerns over of a lack of recognition.

Barr et al (2005, p. 126) draw on Bourdieu's concept of *habitus* to describe identity as

> 'the meeting between culture and self'

They suggest that cultural context is important to understanding interprofessional education and collaboration. According to Webb et al (2002), *habitus* refers to the partly unconscious 'taking in' of rules, values and dispositions. These values and dispositions are gained from our cultural history and generally stay with us across contexts, allowing us to respond to cultural rules and contexts in a variety of ways:

> 'In order for a habitus to function smoothly individuals must normally think that the possibilities from which they choose are in fact necessities, common sense, natural or inevitable. Other possibilities are ruled out precisely because they are unthinkable'
> (Webb et al, 2002, p. 38)

These ideas help us to understand the *breadth of perspective* described by many respondents as a key feature of their identity. Drawing on two discourses renders their cultural trajectory and therefore their identity substantially different to that of the singly trained practitioner. Joint training allows other possibilities to be 'ruled in'. Graduates exercised a range of job choices and some switched between disciplines. Switching could lead to an unsettled habitus. However, the data suggests that placements in culturally and professionally diverse contexts extended the vision of the scope for practice of these practitioners and did quite the opposite. It developed self confidence. Consequently respondents appeared to be critical of 'rule bound' approaches, their critical perspectives on being 'boundaried' providing evidence of the desire to push back the frontiers of individual practice. Views expressed on the value of having one practitioner in learning disability are suggestive that some believed in the possibility of new professional habitus, drawing on two sources of cultural capital (Bourdieu,1998).

The *unavoidable* breadth of vision held by these practitioners meant that they could not easily apply a singular set of rules, values and dispositions to their practice. Respondents' inability to fully differentiate the skills of nursing from those of social work suggests that they had integrated two cultures and two discourses. Even though singularity of professional role was forced on them by the circumstances of employment, the influence of their alternate discipline was very evident.

There was some evidence from the research that some *singly* trained practitioners found joint training 'unthinkable', perhaps because it was likely to upset the professional status quo. This unthinkability may account for the early resistance to the training by some members of a learning disability nursing profession feeling under threat. McCray (2002) identifies the tension, threat and identity concerns expressed by some nurses when the need for the specialist learning disability nurse was questioned during the 1990s.

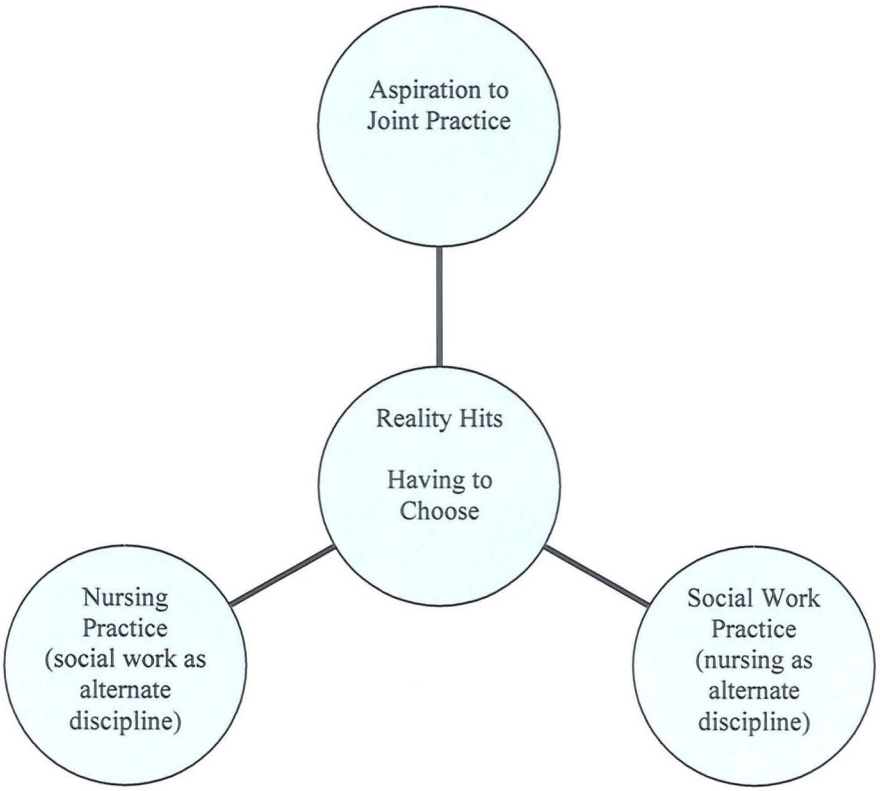
Reflections of respondents on their experiences of entering employment at the point of qualification illuminate an aspect of identity unique to them. Most professional training leads to integration into a singular profession at the end of the training. This can entail some anxiety about initial competence as the person moves from student to qualified practitioner mode, highlighted in chapter three with reference to research by Gray and Smith (1999). Similar anxieties were acknowledged by respondents in my study, especially related to their knowledge or clinical skills in nursing and the fact that they might be perceived as experts in their alternate discipline, whilst not feeling secure in their knowledge of it.

However, a key difference in starting out for these graduates was that career pathway was not automatic but entailed an active and forced choice to select one of two directions. The choice involved selecting a primary discipline and taking up employment in that field. It was likely that career choice would be influenced towards the discipline where there was less anxiety. Even if this was not the case, having to choose involved rejecting one side of respondents' professional selves. This choice making may be seen as a particular rite of passage for the newly jointly qualified practitioner (see Figure 6).

One respondent described the paradox of having to choose a particular role upon qualification as a 'double edged sword', meaning that the greater range of opportunities were halved once the options were narrowed down by choosing one profession.

In singular professions, at the point of qualification graduates would normally be looking forward to developing their identity and singular skills further, by joining their professional association. Biggs (1997) asserts that professional associations serve as anchors to reflect and inform professional identity beyond identification with any single workplace.

Figure 6: The Pathway into Practice for Jointly Trained Graduates



However, in the case of the practitioners in this study, it can be argued that they were using their *workplace* as the anchor to an identity. Their security of identity lay in role security combined with the resilience to adapt flexibly to that role.

Additionally, many of the jointly trained graduates had to manage the disappointment and anxiety of losing skills or leaving them to go undeveloped. Whilst the concern over skills levels may be a common one for a range of newly qualified professionals, they would not generally be contemplating the loss of skills immediately they graduated. To graduate and enter their first employment with a sense of loss is possibly an experience unique to these jointly trained practitioners.

Two strategies were apparent from the data as to how respondents managed the dichotomy of losing skills. One was to take up part-time work in the alternate discipline. The other was to 'switch' professions. It was perceived by some respondents, however, that switching at an advanced point in their career would be very difficult and might be financially impossible as they would have to start at the bottom in the alternate discipline.

7.1.1 Multiple and Changing Identities

Data from both the survey and the interviews suggest that graduates' constructions of their identities are individualised, subject to change and decentred, having no fixed core or centre (Hall, 1992). The assertion by Cook et al (2003) that professional identity is an evolving process throughout a career is difficult to measure in this study, although it was noticeable that respondents who were the longest qualified had retained a belief in the special nature of their training and its value in terms of developing new approaches to practice. One of them, who qualified in 1995, acknowledged the tensions in the training and felt these made its application to practice even more relevant. He felt that these tensions mirrored some of those in practice. Having to integrate two disciplines reflected changes encountered in practice, where services were integrating locally. As a manager of a multidisciplinary team he had to facilitate this. He felt his joint training helped him in this work:

> *'For me it is the knowledge that I don't need that professional identity. I don't have to hide. I feel robust enough in my own skills and abilities not to require that sense of identity I suppose. I think that is really helpful because it gives other people the confidence to come out of their professional fields and start to work across some of those boundaries'.* (Int 23)

As we saw in chapter three, Edwards (1997) observed that identities have become multiple and changing. This aspect is clearly reflected in two other respondents' perceptions, both of whom saw themselves as neither a nurse nor a social worker. One person described his identity as *fluid* and dependent on the environment he was in:

> *'In the present role I am in I do a lot of liaison with the inpatient forensic services, so if I go along there I very much sell myself as a nurse because I fit in better to that professional group, whereas if I am doing a child protection issue*

at...(the Social Services Department)... for instance, I would sell myself as a social worker as I would fit in more with that professional background'. (Int 15)

The other respondent was employed as a training manager, but when she considered it useful she would disclose her nursing identity to gain or maintain the trust of parents or nursing colleagues. This potential to become chameleon-like and adopt a *contingent identity* is clearly one of the unique aspects of identity that joint training confers on its graduates. For these practitioners identity has become fragmented but also gives them constructive options.

The uncertainty, instability and fragmentation of identity is nowhere better illustrated than in the anomaly of learning disability nursing being referred to as *old school social work* by one respondent. One profession being defined in terms of the other. This may be reflective of the elusive concept of postmodern identity (Bauman, 1996) and clearly demonstrates that identity is complex for these practitioners.

Other respondents working as social workers had also found the nursing aspect of their identity useful to reveal when establishing rapport, especially with parents of disabled children, who found this reassuring. In their research to determine the qualities of a learning disability practitioner, McCray and Carter (2002) found that the specialist RLDN attracted considerable praise from parents and carers and held credibility. For many respondents in my study nursing had a much better public image than social work. Therefore at the right time and in the right place the nursing identity could be used to good effect.

7.1.2 Professional Socialisation and Joint Training

Fitzpatrick et al (1996) assert that the principal aim of pre-registration nursing programmes is to socialise students into the professional role:

> 'Understanding the nurse role is critical to effective socialisation during the education programme, culminating in a professional who possesses a sound knowledge base, clinical proficiency, and with attitudes favourable to client and consumer participation'
> (Fitzpatrick et al, 1996, p. 508)

Joint training, however, attempts to achieve socialisation into an undefined identity reflecting two discourses. The data reveal that the characteristics of the socialisation process of the jointly trained practitioner are different to those of a singly trained practitioner, their experience being redolent of *duality* and having to 'balance' the professional perspectives. Paradoxically, the training socialised these graduates against an overly singular role, but the data shows this is exactly where the majority had to take up employment.

The experiences reported by respondents and the structure of the training indicated in programme handbooks highlight a number of key differences in socialisation compared with single profession training. This manifests itself through several elements identified in Figure 7 below.

Figure 7: Elements of Dual Socialisation in a Joint Training Programme

- experience of practice placements in both health and social services, developing a cultural awareness of different organisations
- experience of practice supervision from both nurses and social workers informing both sets of skills
- influence of singly trained lecturers from both disciplines
- learning the 'language' of both nursing and social work
- extensive shared learning with other nurses and/or social workers
- adherence to two different codes of practice
- assessment against a framework of integrated learning outcomes

These elements all contribute towards a duality of identity for the jointly trained practitioner. Figure 8 below indicates the process by which graduates come to appreciate and deploy their breadth of perspective arising from this duality. One respondent said that 'health and social care' was a *mantra* used by lecturers throughout his training, demonstrating just how much educationalists engaged in framing the dual identity. The data reveals there was an understanding by respondents that they had learned to see health and social care as two sides of the same coin and

that their breadth of knowledge had given them the scope to cross boundaries and build bridges between the two domains.

This appears to be consistent with what Ovretveit et al (1997) propose, namely that practitioners in modern health and social services need more than just profession specific competency but also a knowledge of what other professionals can and cannot do and the skills to be able to successfully work with them. The data suggest that jointly trained practitioners met this requirement, despite the limited opportunity to deploy their 'duality' effectively. The training therefore appears consistent with the theory of developing good collaborative practice through IPE although there is a 'disconnect' with practice at the end of it.

Figure 8: The Early Experience of Practice of Jointly Qualified Graduates

Aspiration to use all the skills

Forced to choose a primary discipline

Anticipatory anxieties and self doubt

Feeling unprepared

A period of skilling up

Locating the boundaries of role

The dilemma of registration

Eventual realisation of breadth of skills

Using the skills of the alternate discipline

When compared with single professional training, some common experiences appear to be shared by both singly and jointly trained practitioners in the socialisation process. For example, Gray and Smith (1999) observe that during single nurse

training each student's practice pathway is different and this can impact differentially on their skills and confidence. The combination during training of a good mentor, an assertive student and good learning environment are seen as a key to successfully overcoming doubts and uncertainties. These authors recognise that every student experiences mentors and environments of different measure, which will impact on their development in individualised ways. The findings of my study suggest that jointly trained practitioners have a very similar learning experience.

Managing uncertainties in professional practice is seen by some authors as a part of the art of practice and the development of professional identity (Lingard et al, 2003). It is not uncommon for singly trained nursing students to fail to understand their professional role fully by the end of their training, with clearer perceptions being developed in the post-registration period (Fitzpatrick et al 1996). This is another feature of socialisation singly and jointly trained practitioners appear to share. Respondents experienced doubts and uncertainties on qualification which then appeared to 'settle' given time to evaluate and appreciate the extent of what they had learned. Such doubts and uncertainties may not therefore be uniquely a result of joint training, but a part of the development process for graduates undertaking professional training.

7.2 The Skills of the Jointly Trained Practitioner

7.2.1 Two Discourses, One Practitioner

Evidence from the data revealed that the skills which were considered most important to graduates were those of communication, teamwork and interprofessional working. The majority of survey respondents regarded communication and interprofessional working as areas of knowledge and skills they used most in their jobs. Interview respondents particularly highlighted networking and teamworking abilities as strengths derived from the training. Other aspects of these skills included transcultural understanding and professional empathy. Barr et al (2005) acknowledge the influence of communication and language on effective collaboration and particularly the importance of practitioners understanding other key healthcare discourses and not just

the vocabularies which are part of them. As a more inclusive concept than language, a *discourse*

> 'reflects and moulds professional beliefs, attitudes, perceptions and values'
> (Barr et al, 2005, p. 2)

These authors state that awareness of key discourses is derived from breadth and depth of educational preparation. Whilst there were tensions between the breadth and the depth of the training for some graduates, development of understanding about two discourses is very evident from the data analysis. One respondent reflected on this:

> *'we were looking at two cultures weren't we? We were trying to assimilate two cultures into one person and we were being taught by two cultures and there were significant differences between mornings and afternoons in terms of the culture of the lesson and the content of the lesson'.* *(Int 04)*

The duality of this experience has the potential to bring the jointly trained practitioner close to Barnett's concept of the *critical professional*, whose art lies in handling multiple discourses. Barnett (1997) asserts that the modern professional has to be able to manage incoherence. This is not just about competing demands on a professional's time, but also

> 'competing demands on how they might live out their professionalism: this is the challenge that faces professionals on daily business'
> (Barnett, 1997, p. 141)

These words may summarise very aptly the experience of those who are jointly trained and cannot 'unknow' what they have learned about their alternate discipline.

The context of this professionalism is the increasingly complex and interdependent world in which professionals operate, where there are multiple discourses through which they can interpret professional life. Clearly, in the case of the jointly trained professional, there are two specific discourses, which offer different perspectives on the same client group. Familiarity with both discourses offers broader possibilities for action but also brings with it ambiguity.

Barnett (1997) asserts that the critical professional constructs their own professional identity through critical thought and action, but also by deciding which values, frames of reference and concepts have a claim on their professional self. Faced with different possibilities for action and future role, the jointly trained practitioner has to determine the direction to take. Interestingly, a number of respondents appeared to resort to constructing their dual professionalism by stealth, using their alternate discipline opportunistically.

7.2.2 Skills for Interprofessional Working

To contextualise the findings in the data, it is appropriate to reflect on what the literature says about the requisite skills in the *field of learning disability* relating to inter-professional work. In research to identify the changing educational needs of learning disability nurses, the ENB (1996b) concluded that all nurses needed inter-professional and multidisciplinary teamworking skills, the ability to network, and skills in multi-professional assessment and care planning. Learning disability nurses specifically needed to be proactive in coordinating multi-professional services and to have effective inter-agency skills. They also needed negotiation and communication skills and health care and health promotion skills.

Two of the key findings identified by McCray and Carter (2002) were the need for the learning disability practitioner to promote and support the health and wellbeing of individuals and to be part of a 'professional package' which met the needs of the person with learning disabilities. The practitioner was perceived to need awareness, observation and intervention skills deriving from direct experience of health care, although did not necessarily need to *provide* a large range of interventions themselves. The key was that to be effective the practitioner needed to have an holistic approach. Additionally, the research found that participants believed that

> 'a truly effective learning disability worker also needed social work skills' (McCray and Carter, 2002, p.1384).

This study suggested that the separation of professional roles in learning disability services *could* contribute to the marginalisation of service users.

The outcomes of these two pieces of research clearly have similarities. However, one of them concludes that it is *nurses* who need these skills and the other that they are needed by an 'ideal type' of practitioner in learning disability services. The second research study clearly links to the findings of this thesis in that it underlines the value of healthcare perspectives and knowledge to the practice of those employed in social work and the secondary social work skills for those employed in nursing. Both studies identify characteristics that many respondents in my research felt that they had gained through joint training, including networking ability, teamworking and health promotion skills.

McCray (2003a) notes the uncertain foundations to collaboration in learning disability services due to unclear boundaries. In her research about interprofessional practice with learning disability nurses (four of whom were jointly qualified) she found that the role of the nurse was seen positively, assertively and expansively:

> 'A broader role for the RLDN is set within a positive and secure professional identity, which seeks to embrace a holistic advocate role with that of a change agent'
> (McCray, 2003a, p. 1343)

This *security* of the nursing role may well be why practitioners working as nurses in my study viewed it so positively, in contrast to the experience of some respondents who had entered care management. Although the traditional picture of nursing is sometimes one of a hierarchical profession, it appears from the data that within contemporary nursing practice there are opportunities to be creative in role, and importantly, to carry out direct work. A number of jointly trained practitioners had realised this and aspired to enter nursing, some being prevented from doing so by the lack of available posts.

McCray (2003b) uses the term 'contextual socialisation' to denote an important characteristic needed by practitioners who practise in services for people with learning disabilities, as these are subject to change, ambiguity and boundary shifts. Knowledge of context includes recognition of resource constraints, awareness of agency barriers and the political climate, and the power of professional values. These are all arguably aspects reflected in the data collected in my study and appear

to be elements of the *bigger picture* described by respondents in both stages of the research.

Perhaps paradoxically, McCray (2003b) found that practitioners held a degree of security in their role despite the contextual ambiguity. This security was

> 'based on their acceptance of a practice environment which has few certainties, an acknowledgement of sophisticated relationships, a critical understanding of the role of other professionals, an adaptability of the role based on the particular context of practice and the power to practice to ambiguous boundaries' (McCray, 2003b, p. 391)

Role security here appears to reside in the confidence to adapt to the prevailing circumstances. The stories of respondents in my research indicated that adaptability and confidence were prevalent in their behaviour as they moved into singular roles on qualification or switched roles to further their own career development. In their interviews many respondents showed a critical awareness of political and structural contexts and some had challenged other professionals where professional power or values potentially disadvantaged service users.

What may have enabled this flexibility to adapt to different roles and circumstances is the fact that these practitioners demonstrated skills derived from the outcomes of effective interprofessional education. Whittington (2003b) states that these are the ability to learn, negotiate and apply what is *common* to professions, their *distinctive contribution*, what is *complementary* between them and what may be in *tension or conflict* between them. Jointly trained practitioners arguably *embody* what is complementary between learning disability nursing and social work.

7.3 Influences on Practice

7.3.1 Holistic Reflective Practice

One of the most significant aspects to emerge from the data was respondents' claim to holistic practice. This was perceived to have been an outcome of the training.

Mathias et al (1997) assert that holism is about the integration of professional activity to bring about a balanced programme of health and social care sensitive to the physical, psychological, educational, social and spiritual needs of the service user.

Services can be holistic but so can practitioners. The term holistic was frequently used by respondents to suggest that they had an extra dimension to their practice. It is a term, however, which means different things to different people. This fact was captured by one nurse respondent, referred to earlier in this thesis, who remarked in interview:

> *'I think as a joint practitioner your definition of holistic would probably be bigger than a nurse's'.* *(Int 25)*

He suggested that awareness of the broader social context of the service user, not just the health context, was the defining difference. He referred to the important influence on his nursing practice of having done an extended social work placement during his training. As a jointly trained practitioner he believed that his definition of 'holistic' combined both the health and social paradigms.

Survey respondents talked about holistic approaches, holistic care and holistic knowledge as advantages derived from joint training. Ruch (2005) seeks to define holistic understanding, which she says

> 'recognises that when considered 'holistically' individuals are complex, multifaceted and more than the sum of their parts'
> (Ruch, 2005, p. 113)

Ruch asserts that the holistic nature of practice lies in the relationship between the practitioner and the service user. The former is required to develop and sustain a supportive relationship in often challenging situations, and requires the practitioner to move away from procedural and legalistic responses to a form of holistic practice based on uniqueness and uncertainty.

These ideas illuminate respondents' expressions of dissatisfaction with care management, whose proceduralism obstructed relationship based practice. The data reveals that care managers felt boundaried by the limits of their *assessment only* role.

As highlighted in chapter six, criticisms of the care manager role focused on the lack of opportunity to undertake direct work or intervention. Perhaps these frustrations were an expression of the inability to practise holistically by practitioners trained to perceive and respond to service users and their situations in multifaceted ways? Whilst their identity made holistic thinking inevitable, holistic practice was constrained by requirements of role.

There may be another explanation, linked to the theory of professionalism discussed earlier in this thesis in chapter three. Choosing between nursing and care management may be a choice between two forms of professionalism. Evetts (2006) refers to these as *organisational professionalism* and *occupational professionalism*. The former is described as

> 'a discourse of control used increasingly by managers in work organisations' (Evetts, 2006, p. 140)

This incorporates such features as hierarchical authority, standardised work practices and target setting, aspects which are familiar to many care managers and limit professional autonomy. *Occupational professionalism*, by contrast, is similar to traditional professionalism, in that it:

> 'involves a discourse constructed within professional groups themselves that involves discretionary decision-making in complex cases, collegial authority, the occupational control of the work and is based on trust in the practitioner by both clients and employers'
> (Evetts, 2006, p. 141)

In their critiques of care management activity, some respondents expressed a preference for a role in which they felt they could more fully actualise the potential that joint training had offered them to influence outcomes for service users. Such a role could give greater autonomy of action, more therapeutic value and more discretionary decision making, with less control by managers. For some respondents this role was associated with nursing.

Returning to the issue of holistic practice, Ruch (2005) draws a link between holistic practice and *reflection* and asserts that reflective practice acknowledges the relevance

of diverse sources of knowledge including technical-rational but also critical knowledge. Clearly, in terms of technical rational knowledge jointly trained practitioners have two specific professional paradigms to draw from, and the data provides evidence that both were influential. But the research also reveals the critical knowledge demonstrated through respondents' *boundary talk*, where comment was made about the observed behaviours of singly trained practitioners and the potential value of one practitioner who could carry out both a nursing and social work role. Johns (2004) establishes a connection between reflective and *holistic practice*, which are perceived to be in a symbiotic relationship. He asserts that reflective practice will flourish in a culture which values holistic practice. Relating this back to the data, it was shown that restrictions were placed on some respondents employed as care managers in respect of the detail of their health assessments. In one example, a respondent employed as a care manager in a multidisciplinary team was required to call in a nurse, to do a health assessment. A positively holistic and reflective culture might have valued the opportunity presented for innovation by the presence of a jointly trained practitioner. Respondents were fully aware where such opportunities were missed.

Jones and Joss (1995) also comment on the relationship between reflective and holistic practice. They argue that the values base of the reflective practitioner is

> 'client centred, socially constructed and holistic'
> (Jones and Joss, 1995, p. 24)

and assert that the reflective practitioner sees him or herself as a facilitator whose role is to find the optimal course of action needed. They argue that a reflective practitioner's theory base gives priority to social relations, includes the client's knowledge of their situation and allows new rules to be created out of practice to make sense of uncertainty.

Applying these ideas to the data collected, it is clear they link to the values identified by respondents, especially in respect of the espousal of a person centred approach and the social model of disability. The latter explores how disability itself can be constructed, and as such forms part of anti-oppressive practice theory which focuses

on rights, power and oppression. The social model is seen to have had a positive impact on practice for people with learning disabilities (Coles, 2001). Respondents' incorporation of this into their values base is therefore consistent with this aspect of reflective practice. Additionally, the evidence that some respondents had *pushed at the boundaries* to develop a more expansive role suggests attempts to create 'new rules' in individual cases where circumstances allowed.

Jones and Joss (1995) contrast a holistic approach to practice with a narrower, behaviourist approach:

> 'Where the behaviourist model is essentially individualistic, the holistic perspective is wider. It recognises the influence of individual experience but also takes account of group processes and the impact of organisational culture and values on the individual's professional performance'
> (Jones and Joss, 1995, p. 28)

Returning to respondents' views about their breadth of knowledge, talk of the 'bigger picture' and their critiques of practice, this wider perspective appears very much present in their professional perspective.

There are, it is important to note, some risks associated with an holistic approach. Allen (2003) identifies some of the problems which can accompany holistic practice, particularly the notion that professionals might possess

> 'a holistic power to discipline and control every aspect of welfare recipients' lives'
> (Allen, 2003, p. 287)

This author perceives risks as well as benefits to the joined up thinking expressed through holism. He suggests this can lead to a new type of welfare professional power, the ability to see everything, know everything and do anything. The risk is that an holistic approach can be seen as infallible and that failure to achieve change in people's lives would then be reflected back onto service users and their own reluctance to change.

The potential for the development of a new professional discipline based on joint training clearly carries with it a risk of the emergence of a new professional identity wielding significant power. There is inevitably a risk in joint training that it could produce superior, high minded practitioners who become powerful players in health and social care and perceive themselves as better trained and qualified than singly trained practitioners. In the research, however, a sense of superiority did not come across. Critiques of other practitioners were frequently objectified rather than personalised and sometimes made semi-apologetically. Positive regard for singly trained colleagues was often stated. It could be that the emphasis on values during the training, the awareness of working with an oppressed group, and tensions involved in balancing two perspectives, diminish the likelihood of developing professional arrogance.

7.4 A New Professional Space

D'Amour and Oandasan (2005) assert that inter-professional collaboration requires professionals to know each other both personally and professionally. This means being familiar with each other's roles, responsibilities and conceptual models. As a consequence this enables practitioners to share common territory. A sharing of territories was reported by respondents in the research, evidenced both by their comments on understanding the language and culture of other practitioners but also by their reflections on duality.

Interview data relating to use of the alternate discipline reinforces how far these jointly trained practitioners felt they were able to cross over into other territory. Their aspiration to use all of their skills suggests many felt they belonged there. Barr et al (2005) assert that boundaries between professions must be permeable and negotiable in order to respond to changing needs. Payne (2002) observes that staying within boundaries may limit the resources of expertise and services available to clients. Respondents perceived they were able to build bridges and cross boundaries. This sense of movement and the flexibility which it implies appear to respond to NHS policy on developing a more adaptable workforce (Department of Health, 2000). Movement and flexibility appear to be characteristics of graduates' professional identity.

Whilst able to move easily into another territory, there is however a sense that jointly trained practitioners occupy a different space in health and social care. Beattie (2003) draws from the field of cultural studies to describe the concept of 'thirdspace' which is apposite here. He describes this as

> 'the unexpected juxtapostions, discordances that generate newness, interstitial structures that are de-centred and create ambivalence – perhaps make you (as an inhabitant or visitor) temporarily 'lose your bearings''
> (Beattie, 2003, p. 152)

This space is neither one thing nor the other

> 'It is a space of 'hybridity', a space of discursive contestation, at the borderlines and crossing borders; and the inhabitants of thirdspace depend for their survival on discovering 'how newness enters the world''
> (Beattie, 2003, p. 152)

The idea of a new conceptual space illuminates the experiences of jointly trained practitioners, who appear to hold an identity between identities. A practitioner can work as a nurse, a social worker or both (concurrently but not simultaneously, as the data reveals). An extract of an interview with one respondent indicates the potential for disorientation, ambivalence and newness, as she questioned her identity at the point of qualification:

> **Respondent:** *What was I? What am I? I become a nurse when I need to be a nurse and I become a social worker when I need to become a social worker. And other people are questioning – what are you then?*
> **Interviewer:** *What impact did that have on you?*
> **Respondent:** *I didn't know what I was – it is much better now.*
> **Interviewer:** *Why?*
> **Respondent:** *Because the actual post I am working in as a primary mental health worker is very much a holistic assessment. You have to look at the family dynamic. You have to look at the health. And social economics. It's ideal for the job I am in.* *(Int 14)*

For this person the ambivalence was resolved by finding work in one of the new roles as in a multidisciplinary CAMH team, for which no single professional background was specified.

The idea of *thirdspace* helps us to locate the jointly trained practitioner at the place where two discourses meet and contest the possibility of a new one. As the concept implies, this is not always a comfortable place to be and as the data suggests can lead to some dissonance because graduates cannot be employed there. It may be that the discomfort of this professional space meant that some respondents sought a more stable professional positioning. Interestingly, there was one interview respondent who wished he had done single qualifying training because he found the teaching of nursing skills on his programme insufficient. He had later retrained in mental health nursing and enjoyed working in 'larger units.' This was in contrast to almost all the other interview respondents, who worked in the community rather than in residential work.

Beattie (2003) argues that the metaphor of *thirdspace* offers a way of engaging with the instability and uncertainty caused where the previous certainties of power and knowledge are destabilised. It is a way of

> 'celebrating definitional uncertainty'.
> (Beattie, 2003, p. 153)

Joint training could also be a celebration of this uncertainty. There is a link here with Bernstein's theory of the regionalisation of knowledge (2000), as thirdspace may well describe the point at which singular disciplines meet and overlap. 'Thirdspace' and the *crucial space* said by Bernstein to lie between discourses occupy the same abstract location but have different characteristics; thirdspace draws the disciplines together and acknowledges their permeable boundaries whereas crucial space separates them and supports their singular definitions.

7.4.1 From Singulars to a Region – towards Interprofessionality

We have seen that Bernstein's work provides a helpful framework for understanding how separate disciplines emerged and established their singularity of purpose and

identity. Knowledge was, however, subsequently reorganised to create regions of knowledge calling some singular discourses into question. D'Amour and Oandasan (2005) assert that the division of professional responsibilities in services results from singularity, based on fragmented disciplinary specific knowledge separated by artificial divisions. They propose a new concept of *interprofessionality* to explain

> 'the development of a cohesive practice between professionals from different disciplines'
> (D'Amour and Oandasan, 2005, p. 9)

This, they propose, will create knowledge about the type of competencies required by practitioners to enable them to work well in settings where collaboration is required. Such competencies have already been proposed, however. Barr et al (2005) describe a comprehensive list of competencies necessary for effective collaborative practice. These contain expected elements such as cooperating and communicating between professionals and agencies. There are, however, four of these competencies which the data in this thesis appear to reflect as particular characteristics of jointly trained practitioners. These are:

- Recognising and observing the constraints of one's roles, responsibilities and competence yet perceiving needs in a wider context
- Ensuring that your professional point of view is heard
- Coping with conflict
- Recognising and respecting the roles, responsibilities and competence of other professions in relation to one's own, knowing when, where and how to involve these others through agreed channels
  (Barr et al, 2005, p. 84)

Each of these competencies is identifiable through the experiences of the respondents in this study: breadth of vision about care needs, assertive management of situations where speaking out is required, balancing the conflicts which dual qualification inheres and use of networks to engage with other professionals. Arguably, these are some of the skills which can enable an integrated approach to care and help professionals to manage the space between discourses. They may also be some of the positive outcomes from the integrated curriculum approach (Barr et al, 2005) that joint training has sought to adopt. These skills may come as much through the

process of joint training as through the content, as students have to negotiate their way through unmapped territories containing pitfalls, obstacles and uncertainties.

7.5 Conclusion

This chapter has discussed the findings of the research in the light of literature reviewed in earlier chapters and new theoretical concepts which have explanatory power in respect of the data collected. The discussion has linked the findings back to the main research question and its three sub questions. In the next chapter a theoretical position will be outlined derived from the analysis of the data and the findings of the research.

CHAPTER EIGHT

Conclusion

8.0 Introduction: contribution to knowledge

This study set out to investigate the influence of joint training on the professional identity, skills and working practices of graduates. It has made an important contribution to knowledge in respect these three elements. In this concluding chapter of the thesis an explanatory theory of the influence of joint training is presented. This theory has been built through the research process and results from the combined activities of literature review, data collection and analysis. The literatures discussed in chapters two and three provided an educational and a professional context for this research. The choice of a flexible design allowed data collection using two different sources and methods, which facilitated triangulation (Robson, 2002). At the data analysis stages grounded theory approaches were used to build theory from the data.

8.1 Towards a theory of the influence of joint training

From an analysis of the data collected a number of propositions can be established which together constitute a theory of the influence of joint training and contribute to the knowledge base about this unique form of interprofessional education. These are as follows:

1. **The professional identity of graduates is complex and indeterminate in character and subject to change. It is, however, characterised by a dual professionalism which is embedded through the process of joint training**

Evidence has been presented to suggest that the construction of professional identity takes different forms in individual practitioners. Jointly trained graduates interpret their identity idiosyncratically and are influenced by the career pathway chosen, as they are unable to maintain the integrity of two professional identities simultaneously and fully in practice because there are no employment roles which enable this. An exception to this is where a practitioner holds a part-time job in both social work and

nursing. Identity may change for graduates as they move from nursing to social work or vice versa.

Graduates from joint training programmes generally describe their identity in terms of their job role but many continue to aspire to an idealised role characterised by the expression 'joint practitioner'. Evidence from this study suggests that no such role exists in practice, although a small number of graduates assumed roles in Child and Adolescent Mental Health teams which allowed role diversity and use of a breadth of skills.

Professional identity for jointly trained graduates is held in tension on a continuum, at one end of which is social work and at the other learning disability nursing. Graduates may locate themselves at different places along a line stretching from one professional pole to the other. A linear model cannot, however, fully explain the complexity of the phenomenon of the identity of the jointly trained practitioner. This is because graduates experience an overlap between the professions in practice, which reflects the original founding rationale for the training.

Identity for graduates is therefore interstitial, integrating features of both ends of the continuum. A key feature of their identity is the unavoidable influence of both disciplines on their professional perspective. This results in a dual professionalism which exists in spite of post qualifying socialisation into singular job roles. Aspects of *both* disciplines therefore remain an integral part of graduates' identity. Testimony of the longest qualified respondents suggests this duality is sustained, embedded in graduates' professional habitus through a prolonged process of socialisation during a three year training. This process frames duality rather than singularity of identity. Jointly trained practitioners embody this duality.

Jointly trained graduates 'ground' their professional identity through comparison with singly, traditionally trained practitioners. A feature of their identity is the presence of a critical perspective on practices which are professionally defensive and boundaried. Their identity is strongly associated with inter-professional work and the importance of direct engagement with service users which is empowering and informed by the social model of disability. Community nursing roles are perceived by many graduates

as most likely to enable them to actualise their potential for integrating approaches from the two disciplines. Care management roles are likely to impede this.

The uncertainty of identity that many graduates experience during the training is not problematic in terms of later professional practice, although a perceived insufficiency of nursing skills may influence some graduates to seek social work as a career. Graduates establish themselves successfully in either profession, although for many having to choose a singular discipline is disappointing and was conveyed as a compromise. Lack of recognition of their training is a shared feature of their identity. In common with other newly qualified professionals, they initially encounter experiences of anxiety, but they are able to recuperate skills deficits they deem themselves to have and to develop a confident assertiveness. Some graduates selectively deploy 'different sides' of their identity where this has benefits for interprofessional relationships.

2. **Jointly trained practitioners integrate the skills from both disciplines into their practice, demonstrated by a breadth of perspective particular to these graduates**

Evidence from the data confirms the possession of a breadth of knowledge by graduates, derived from the duality of their training. This is especially actualised during the process of *assessment* of service users. Only graduates employed as nurses, however, are likely to be able to use the full range of intervention skills learned on joint training programmes.

The majority of graduates are employed in single discipline roles, where their practice is influenced by skills and knowledge from the alternate, unrecognised discipline. For those employed in social work, skills in health promotion and surveillance are used by them to extend their practice to the benefit of service users. For those employed as learning disability nurses, an understanding of the social context of individual problems derived from joint training leads to practice which is characterised by more holistic, sustainable interventions.

Breadth of knowledge is at the expense of depth for some practitioners. Some graduates are not confident in their skills at the point of qualification and need to develop additional learning in their first post. Support is offered for this in some cases. There is, however, no support offered to graduates to develop their joint identity or to actively maintain their skills in the alternate discipline. There is therefore a risk that the skills of the alternate discipline will be lost or become out of date.

Jointly trained graduates develop a strong awareness of two different professional discourses. In their practice they are able to move comfortably between nursing and social work settings, having benefited from placements in both. Practice placement experience in multidisciplinary teams enables them to develop an understanding of and sensitivity to the cultures, professional perspectives and language of other professional groups. This enhances their communication skills and their ability to work collaboratively in teams. Diversity of placements during the training develops confidence in networking widely to achieve successful outcomes for service users.

Evidence from the study suggests that, paradoxically, jointly trained graduates are sometimes discouraged from using skills and knowledge of their alternate discipline where these might otherwise render a more timely and efficient service to service users. The presence of these knowledge and skills remain, however, a part of their professional self awareness.

3. **Jointly trained graduates develop a critical perspective on practice which enables them to manage change and uncertainty and to develop resilience**

Evidence from the findings suggests that practitioners have to manage conflict in their learning experiences from the outset of the training. Tensions in the processes and delivery of the training and criticisms of its outcomes mean that graduates have to explain or defend it as a part of their ongoing development. This enables those who qualify to critically evaluate their practice and that of others, evidenced by views expressed in their 'boundary talk'. This critical perspective also enhances the ability to challenge where poor practice is observed.

These critical perspectives provide evidence of reflective practice. The data suggests that during their pre-qualifying training, jointly trained graduates develop a broader overview of practices, services and professional behaviours than singly trained practitioners. This overview comes from the diverse elements of the training, particularly the placement experiences with different professionals in different services. This, combined with having to negotiate the boundaries of roles and identity, help them to develop holistic practice.

Working practices of graduates are influenced by a greater awareness of possibilities, emerging from this broad overview. Confidence to challenge and loss of deference combine to develop assertiveness. Some respondents believe there are creative opportunities offered by the training and these were evidenced in the data by examples of collaborative work and where graduates had pushed at boundaries and worked beyond the limits of their role.

Managing two professional paradigms requires the ability to adapt and be flexible but also appears to develop it. Uncertainty and ambivalence are aspects of the socialisation process experienced by these graduates. Placements in different settings, supervision from a range of professionals, and teaching from different staff teams are all features of the training which assist this development. Some practitioners are able to switch roles with relative ease, evidencing this ability.

4. **Joint Training represents a merging of discourses and illustrates how the singularity of professions can be deconstructed and a new region of knowledge begin to emerge in the field of learning disability**

Evidence of graduates' duality of perspective, and their testimonies to the inseparability of the skills of learning disability nursing and social work, suggest that a new conceptual space is emerging which integrates the knowledge and skills of the two disciplines. The majority of practitioners interviewed gave examples from practice in which they believed they had deployed these knowledge and skills whilst employed in singular roles. Graduates can be seen as custodians of a new region of knowledge which is under (social) construction. Socialisation into two professions

simultaneously challenges the ability of singular discourses to fully explain and respond to the needs of people with learning disabilities.

Their dual socialisation is such that it means graduates have difficulties in deconstructing the new region into two discreet discourses. Whilst the degree of influence of this socialisation differs for each individual, it is manifestly evident. The extent to which the two discourses can become one in practice is limited by singular role boundaries and the dominance of the two traditional professions in services. However, there is evidence that graduates construct their professionalism from both.

The tensions, conflicts, anxieties and uncertainties described by jointly trained practitioners are indicative of a paradigm shift. Graduates are architects of change as much as they are victims of it. The unfulfilled desire to use all of their skills suggests there is scope for role changes in services to allow these graduates to occupy an extended professional role provided that professional accountabilities are clear. Were such a role to exist, it would be a further step in the direction of a combined discourse in learning disability nursing and social work practice.

Evidence from this study suggests that the parallel teaching of two discourses is a form of discourse deconstruction. The appropriateness of the two singular discourses to separately convey the full picture of the required professionalism for working with people with learning disabilities is contested by the presence of these practitioners. In their talk these graduates have constructed a new version of events which give health and social care perspectives equal importance in their practice. They have taken in the values and dispositions of a new, as yet undefined or recognised *habitus*, based on a broader cultural capital than that of singly trained practitioners. Joint training programmes have not fully framed a new discourse but they have upset the equilibrium of existing ones. Programmes have developed graduates' awareness about the value of combining two professional perspectives and the relevance of this to meeting service users' needs. The resulting practitioners are *specialist* practitioners in learning disability.

A new discourse is in nascent form in this relatively small number of graduates. There are, however, no signs that a professional lobby or consensus for a 'new

practitioner' is underway. Indeed, the recent *professional renewal* of both learning disability nursing and social work are likely to establish a counterweight to any such change. However, new discourses emerge when their versions of events are sufficiently convincing or consensual or have a stronger descriptive power than those they are replacing.

8.2 Joint Training and a Changing Professionalism

As discussed at the beginning of this thesis, joint training is an example of change in contemporary professionalism influenced by education. Changing professionalism means that the roles and identities of health and social care professionals are subject to scrutiny, driven by critiques of professionalism, the complexity of service users' needs and the demands for a more interprofessional approach. Professional education contributes to this change and joint training can be seen as an example of a search for a new way of explaining and practising. As Gergen (1999, p.48) states:

> 'as we describe, explain or otherwise represent, so do we fashion our future'. (Gergen, 1999, p. 48)

The increasing integration of health and social care services has created potential opportunities for these graduates to implement policy on joined up working and work across traditional boundaries, using their transcultural understanding to manage complex collaborative working. If allowed to do this they could become representatives of a new professionalism.

That new professionalism is within the reach of a range of professionals. It involves greater accountability for practice based on transparency in professional life. Whilst in some respects this means that professionals can be subject to more managerial or bureaucratic control, it also enables the breaking down of barriers between professional groups. Professionals cannot deny similarities and overlaps in their roles and functions where these have been proven to exist.

Interprofessional education can help to build a new professionalism by establishing collaborative working as a new priority for practitioners. The evidence in this thesis suggests that IPE encourages and develops an openness in the professional lives of graduates which has the potential to counteract professional defensiveness and

unhelpful singularity. It means that *new professionals* can learn to reconstruct their identities and renegotiate their roles as a part of their daily practice. The graduates in this study arguably provide a model of how this can be achieved.

8.3 Reflections on the Research Process

The research strategy adopted in this study aimed to put practitioners' perspectives and experiences centre stage. The focus on their interpretations enabled both diversity and commonality of experience to be uncovered. Whilst the presentation of the thesis follows a linear model, in reality the different stages of the research process overlapped. The result was an iterative and evolving process combining literature review, data collection and analysis over a period of 30 months. Additionally, although the study began in 2004, earlier learning on the EdD programme also informed it. This learning was referred to in the integrating statement at the beginning of this study.

As the study evolved, and particularly during the second data collection stage, my conception of the 'joint practitioner' came under close personal scrutiny. This term had been commonly used during my involvement with joint training to denote the identity of the emerging practitioner. It became clear to me during the interview stage that this term was part of the enigma of identity surrounding the training. Whilst it provided a useful 'hook' on which to hang the hats of two disciplines, its use ironically indicated the wish to singularise the identity of the jointly trained graduate into a form that would capture duality. The result was a term that was inspirational to students and visionary for educators but paradoxical because even after nearly two decades no respondents had occupied such a role in practice.

Undertaking this study has developed my understanding both about the research process and about joint training. I have learned that the process of research can be 'untidy'. This was particularly the case during the survey stage, when depending on the assistance of intermediaries in different universities offering the training felt as if the process was 'out of my hands'. The participation of these colleagues was, however, invaluable and without their support the sample of respondents would have been much reduced in size.

In terms of my own professional practice, the study has emphasised for me the significance of the changing professionalism in health and social care. This will have implications for my teaching of social work students, whose health care awareness and collaborative abilities could be significantly enhanced by more shared learning with nurses. There is an opportunity for development of this in my university and I will be looking to participate in this development.

This study has also raised my awareness about the need for further research in the area of joint training. I believe research in the following areas would complement the outcomes of this study:

- National research with the support of the GSCC and the NMC to establish the number of jointly trained practitioners in the workforce and identify their work activities
- Comparative research in respect of the outcomes of joint training programmes and those of single training programmes in nursing and social work
- Research into the perspectives of employers on the contribution to practice made by the jointly trained graduates they have recruited
- Action research to pilot the role of a 'joint practitioner' in learning disability services and evaluate its outcomes

The perspectives of people with learning disabilities and their families are essential to the process of establishing the most effective and responsive service. Research on a national scale is needed to establish whether jointly trained practitioners can bring continuity of care and an holistic service. This would help to establish whether there is a role for this 'new' professional in meeting one of the aims of specialist services, which, according to the 2001 Valuing People White Paper,

> 'should be planned and delivered with a focus on the whole person, ensuring continuity of provision and appropriate partnership between different agencies and professions'
> (DH, 2001b, p. 68)

During this study a number of paradoxes have been identified. Perhaps the most significant of these is that joint training has continued to be commissioned over a period of 18 years but with little formal research being carried out in respect of its outcomes. The 'leap of faith' has been a very long one. Significant financial investment has been made in developing practitioners on the basis that this type of training is inherently 'a good thing'. Joint programmes have also been established in mental health, the most recent of which was in 2006. Yet there is no formal evidence base. This study constitutes a major contribution.

8.4 Modes of Dissemination

During the research process I advised respondents that I would send them a summary of the research once it was completed. This was important for two reasons. Firstly, respondents had given up their time to be involved, so this would give a measure of reciprocal gain. Secondly, most people were very interested in the topic and enthusiastic to receive information about any publications which might result. As a method of dissemination this would ensure that those people with a high degree of interest in the study would be kept informed.

Additionally, a summary of the thesis will be offered to the universities involved, as their lecturers and joint training students would be expected to benefit from being aware of its outcomes, given that it provides a contribution to the very small evidence base about joint training.

A key aim will be to publish from the thesis in both nursing and social work journals, to achieve maximum dissemination to the two professional groups to whom it may be of interest. These will include publications such as the Journal of Advanced Nursing, the British Journal of Nursing, the Journal of Social Work Practice and Social Work Education. I will aim to submit a paper to the Journal of Inter-professional Care and undertake appropriate conference presentations. As a small step on the road to publication, a short article based on the initial findings was published in Community Care magazine in 2006.

It will require a new vision in services to develop 'joint' roles in practice which graduates can take up on qualification. The full potential of those who receive this

training will then be able to be objectively evaluated to establish its impact on services for people with learning disabilities and their carers. Joint training was set up with their benefit in mind. This study demonstrates that a part of the joint training 'vision' has been fulfilled. The full potential is yet to be realised.

REFERENCES

Abbott P. and Meerabeau L. (1998). 'Professionals, Professionalisation and the Caring Professions', in Abbott P. and Meerabeau L. (eds.) *The Sociology of the Caring Professions (second edition)*. London: UCL Press.

Abbott P. and Wallace C. (1998). 'Health Visiting, Social Work, Nursing and Midwifery: a History', in Abbott P. and Meerabeau L. (eds.) *The Sociology of the Caring Professions (second edition)*. London: UCL Press.

Allen C. (2003). 'Desperately seeking fusion: on 'joined-up thinking', 'holistic practice' and the *new* economy of welfare professional power'. *British Journal of Sociology*, 54 (2), 287-306.

Barnes D., Carpenter C. and Dickinson, C. (2000). 'Interprofessional education for community mental health: attitudes to community care and professional stereotypes'. *Social Work Education*, (19), 565 – 583.

Barnett R. (1997). *Higher Education: A Critical Business*. Buckingham: Open University Press.

Barr H. (1998). 'Competent to Collaborate: towards a competency-based model for inter-professional education'. *Journal of Interprofessional Care*, 12 (2), 181-187.

Barr H. (2002). *Interprofessional Education: Today, Yesterday and Tomorrow*. London: Learning and Teaching Support Network for Health Sciences and Practice, Kings's College.

Barr H. (2004). 'Introduction', in Meads G. and Ashcroft J. (2005*) The Case for Interprofessional Collaboration in Health and Social Care*, London: Blackwell/CAIPE.

Barr H., Hammick M., Koppel I. and Reeves S. (1999). 'Evaluating Interprofessional Education: two systematic reviews for health and social care'. *British Educational Research Journal*, 25 (4), 533-544.

Barr H., Koppel I., Reeves S., Hammick M., and Freeth D. (2005). *Effective Interprofessional Education. Argument, Assumption, Evidence*. London: Blackwell/CAIPE.

Barrett G., Greenwood R. and Ross K. (2003). 'Integrating interprofessional education into ten health and social care programmes'. *Journal of Interprofessional Care*, 17 (3), 293-301.

Barrett G. and Keeping C. (2005). 'The Process Required for Effective Interprofessional Working', in Barrett G., Sellman D. and Thomas J. (eds.) *Interprofessional Working in Health and Social Care*. Basingstoke: Palgrave Macmillan.

Bauman Z. (1996). 'From Pilgrim to Tourist – or a Short History of Identity', in Hall S. and du Gay P. (eds.) *Questions of Cultural Identity*. London: Sage.

Beattie A. (2003). 'Journeys into thirdspace? Health Alliances and the challenges of border crossing', in Leathard A. (ed.) *Interprofessional Collaboration. From Policy to Practice in Health and Social Care*, Hove: Brunner-Routledge.

Beck J. and Young, Michael F. D. (2005). 'The Assault on the Professions and Restructuring of academic and professional identities: a Bernsteinian Analysis'. *British Journal of Sociology of Education*, 26 (2), 183-197.

Bendle M. F. (2002). 'The crisis of 'identity' in high modernity'. *British Journal of Sociology*, 53 (1), 1-18.

Bernstein B. (2000). *Pedagogy, Symbolic Control and Identity. Theory, Research, Critique. Revised Edition*. Lanham: Rowman and Littlefield (USA).

Biggs S. (1997). 'Interprofessional Collaboration: Problems and Prospects', in Ovretveit J., Mathias P and Thompson T (eds.) *Interprofessional Working for Health and Social Care*, Basingstoke: Macmillan.

Bourdieu P. (1998). *Practical Reason. On the Theory of Action*. Cambridge: Polity Press.

British Educational Research Association. (2004). *Revised Ethical Guidelines for Educational Research*. Nottingham: BERA.

Brown J. (1994). *The Hybrid Worker. Lessons based upon a study of employers involved with two pioneer joint qualifying training courses*. London: CCETSW.

Brown J. and Shaw I. (1989). 'A Foundation for the Future: the concept and implementation of Joint Training'. *Journal of Social Work Practice*, 4 (1), 66-76

Brown L. (1993). *The New Shorter Oxford English Dictionary*. Oxford: Clarendon Press.

Cable S. (2002). 'The Context. Why the Current Interest?' in Glen S. and Leiba T. (eds.) *Multi-professional Learning for Nurses. Breaking the Boundaries*, Basingstoke: Palgrave.

Carlisle C., Cooper H. and Watkins C. (2004). 'Do none of you talk to each other? The challenges facing the implementation of interprofessional education'. *Medical Teacher*, 26 (6), 545-552.

Carpenter J. (1995). 'Doctors and Nurses: Stereotypes and Stereotype Change in Interprofessional Education'. *Journal of Interprofessional Care*, 9 (2), 151-161.

Carrier J. and Kendall I. (1995). 'Professionalism and interprofessionalism in health and community care: some theoretical issues', in Owens P., Carrier J. & Horder J.

(eds.) *Interprofessional Issues in Community and Primary Health Care*, Basingstoke: Macmillan.

Charmaz K. (2000). Grounded Theory. Objectivist and Constructivist Methods, in Denzin N. K. and Lincoln Y. S. (eds.) *Handbook of Qualitative Research. Second Edition*. London: Sage.

Clarke J. (2004). *A Consuming Public*. Lecture in the ESRC/AHRB Cultures of Consumption series, Royal Society, 22nd April 2004. Available at www.open.ac.uk/social sciences/citizenconsumers/cccsubset/cccinfopops /a_consuming_public.pdf. Last accessed 23rd January 2007.

Cohen L. and Manion L. (1989). *Research Methods in Education*. 3rd Edition. London: Routledge.

Cohen Helen A. (1981). *The Nurse's Quest for a Professional Identity*. London: Addison-Wesley Publishing Company.

Coles J. (2001). 'The Social Model of Disability: what does it mean in practice in services for people with learning difficulties?' *Disability and Society*, 16 (4), 501-510.

Cook T., Gilmer M. and Bess C. (2003). 'Beginning Students' Definitions of Nursing: An Inductive Framework of Professional Identity'. *Journal of Nursing Education*, 42, (7), 311- 317.

Cresswell J. (1994). *Research Design: Qualitative and Quantitative Approaches*. London: Sage.

Crotty M. (1998). *The Foundations of Social Research. Meaning and Perspective in the Research Process*. London: Sage.

D'Amour D. and Oandasan I. (2005). 'Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept'. *Journal of Interprofessional Care*, Supplement 1, 8-20.

Davies C. (1996). 'The Sociology of Professions and the Profession of Gender'. *Sociology*, 30 (4), 661-678.

Davis J., Rendell P. and Sims D. (1999). 'The joint practitioner – a new concept in professional training'. *Journal of Interprofessional Care*, 13 (4), 395-404.

Davis J. and Sims D. (2003). 'Shared Values in Interprofessional Collaboration', in Weinstein J., Whittington C. and Leiba T. (eds.) *Collaboration in Social Work Practice*. London: Jessica Kingsley.

Denzin N. K. and Lincoln Y. S. (2000). 'The Discipline and Practice of Qualitative Research', in Denzin N. K. and Lincoln Y. S. (eds.) *Handbook of Qualitative Research. Second Edition*. London: Sage.

Denzin N. K. and Lincoln Y. S. (eds.) (2003). *Collecting and Interpreting Qualitative Materials*. Second Edition. London: Sage.

Department for Education and Skills. (2003). *Every Child Matters: Change for Children*. London: HMSO. Cmnd 5860.

Department of Health. (1989). *Caring for People*. London: HMSO. Cmnd 849.

Department of Health. (1997). *The new NHS: Modern, Dependable*. London: The Stationery Office.

Department of Health. (1998a). *Modernising Social Services*: *Promoting Independence, improving protection, raising standards*. London: HMSO. Cmnd 4169.

Department of Health. (1998b). *Partnerships in action: New Opportunities for joint working between health and social services*. London: Department of Health.

Department of Health. (1999). *Working Together to Safeguard Children: A Guide to inter-agency working to safeguard and promote the welfare of children.* London: Stationery Office.

Department of Health. (2000). *A Health Service of all the talents: Developing the NHS Workforce*. London: HMSO.

Department of Health. (2001a). *Care Trusts. Emerging Framework.* London: Department of Health.

Department of Health. (2001b). *Valuing People: A New Strategy for Learning Disability in the 21st Century*. London: The Stationery Office.

Department of Health. (2002). *Requirements for Social Work Training*. London: Department of Health.

Department of Health. (2004). *National Service Framework for Children, Young People and Maternity Services*. London: Department of Health.

DHSS. (1971). *Better Services for the Mentally Handicapped.* London: HMSO Cmnd 4683.

DHSS. (1972). *Report of the Committee on Nursing (Briggs Report)*. London: HMSO Cmnd 5115.

DHSS. (1979). *Report of the Committee of Enquiry into Mental Handicap Nursing and Care (Jay Report).* London: HMSO Cmnd 7468.

Dominelli L. (2004). *Social Work. Theory and Practice for a Changing Profession.* Cambridge: Polity Press.

Du Gay P., Evans J. and Redman P. (2000). *Identity: A Reader*. London: Sage.

Du Toit D. (1995). 'A sociological analysis of the extent and influence of professional socialisation on the development of nursing identity among nursing students at two Universities in Brisbane, Australia'. *Journal of Advanced Nursing*, 21, 164-171.

Edwards R. (1997). *Changing Places? Flexibility, Lifelong Learning and a Learning Society.* London: Routledge.

English National Board for Nursing, Midwifery and Health Visiting. (1996a). *Guidance on Preparation of Joint Submissions for Pre-registration/Qualifying Programmes*. London: English National Board.

English National Board for Nursing, Midwifery and Health Visiting. (1996b). *Research Highlights. The changing educational needs of mental health and learning disability nurses*. London: English National Board.

Eraut M. (1994). *Developing Professional Knowledge and Competence*. London: The Falmer Press.

Etchells J., Kniveton K., Longshaw K. and Mitchell D. (1999). Dual Qualification Education and Training: the learning disability experience. *Mental Health Care*, 21 (12), 412-415.

Etzioni A. (1969). *The Semi-Professions and Their Organisation. Teachers, Nurses, Social Workers*. New York: The Free Press.

Evetts J. (1999). 'Professionalisation and Professionalism: issues for interprofessional care'. *Journal of Interprofessional Care*, 13 (2), 119-128.

Evetts J. (2003). 'The Sociological Analysis of Professionalism. Occupational Change in the Modern World'. *International Sociology*, 18 (2), 395-415.

Evetts J. (2006). 'Short Note: The Sociology of Professional Groups. New Directions'. *Current Sociology*, 54 (1), 133-143.

Ewens A., Howkins E. and Badger D. (2000). 'Evaluating Interprofessional Education from a Community Nurse and Social Work Student Perspective'. *Research in Post-Compulsory Education*, 5 (1), 5-21.

Fagerberg I. and Kilhgren M. (2001). 'Experiencing a nurse identity: the meaning of identity to Swedish registered nurses 2 years after graduation'. *Journal of Advanced Nursing*, 34(1), 137-145.

Fitzpatrick J.M., While A.E. and Roberts J.D. (1996). 'Key influences on the professional socialisation and practice of students undertaking different pre-registration nurse education programmes in the United Kingdom'. *International Journal of Nursing Studies*, 33 (5), 506-518.

Fowler P., Hannigan B. and Northway R. (2000). 'Community Nurses and Social Workers learning together: a report of an interprofessional education initiative in South Wales'. *Health and Social Care in the Community*, 8 (3), 186-191.

Freeth D., Hammick M., Koppel I., Reeves S. and Barr H. (2002). *A Critical Review of Evaluations of Interprofessional Education*. London: CAIPE.

Freidson E. (1994). *Professionalism Reborn. Theory, Prophecy, Policy*. Chicago: University of Chicago Press.

Freidson E. (2001). *Professionalism. The Third Logic*. Cambridge: Polity Press.

Funnell P. (1995). 'Exploring the Value of Interprofessional Shared Learning', in Soothill K., Mackay L. and Webb C. (eds.) *Interprofessional Relations in Health Care*. London: Edward Arnold.

Gergen K. J. (1999). *An Invitation to Social Construction*. London: Sage.

Gilbert J. H. V. (2005). 'Foreword', in Freeth D., Hammick M., Reeves S., Koppel I. and Barr H. *Effective Interprofessional Education. Development, Delivery and Evaluation*. London: Blackwell/CAIPE.

Gill J. and Ling J. (1995). 'Interprofessional Shared Learning: A Curriculum for Collaboration', in Soothill K., Mackay L. and Webb. C (eds.) *Interprofessional Relations in Health Care*. London: Edward Arnold.

Glen S. (2004a). 'Interprofessional Education: The Policy Context', in Glen S. and Leiba T. (eds.) *Interprofessional Post-Qualifying Education for Nurses. Working Together in Health and Social Care*. Basingstoke: Palgrave Macmillan.

Glen S. (2004b). 'Interprofessional Education: the evidence base influencing policy and policy makers'. *Nurse Education Today*, 24, 157-159.

Gould N. (2000). 'Personal construct theory and the transfer of learning', in Cree V.E. and Macauley. C (eds.) *Transfer of Learning: Theory and Practice*. London: Routledge.

Gray M. and Smith L. (1999). 'The professional socialization of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study'. *Journal of Advanced Nursing*, 29 (3), 639-647.

Hall S. (1992). 'The Question of Cultural Identity', in Hall S., Held D. and McGrew T. (eds.) *Modernity and its Futures*. Cambridge: Polity Press.

Hall S. (2000). Who Needs Identity?, in Du Gay P., Evans J. and Redman P. (eds.) *Identity: A Reader*. London: Sage.

Hall P. and Weaver L. (2001). 'Interdisciplinary Education and Teamwork: a long and winding road'. *Medical Education*, 35, 876-875.

Hammick M. (1998). 'Interprofessional Education: concept, theory and application'. *Journal of Interprofessional Care*, 12 (3), 323 – 332.

Hammick M. (2000). 'Interprofessional Education: evidence from the past to guide the future. *Medical Teacher*, 22 (5), 461 – 467.

Hart C. (2004). *Nurses and Politics. The Impact of Power and Practice*. Basingstoke: Palgrave.

Haslam A.S., Eggins R.A. and Reynolds K.J. (2003). 'The ASPIRe model: Actualising Social and Personal Identity Resources to enhance organisational outcomes'. *Journal of Occupational and Organisational Psychology*, 76, 83-113.

Hind M., Norman I., Cooper S., Gill E., Hilton R., Judd P. and Jones Sue C. (2003). 'Interprofessional perceptions of healthcare students'. *Journal of Interprofessional Care*, 17 (1), 21-34.

Hudson B. (2002). 'Interprofessionality in health and social care: the Achilles' heel of partnership?' *Journal of Interprofessional Care*, 16 (1), 7-17.

Hugman R. (1998). 'Social Work and De-professionalisation', in Abbott P. and Meerabeau L. (eds.) *The Sociology of the Caring Professions (second edition)*. London: UCL Press.

Hugman R. (2003). 'Going Round in Circles? Identifying interprofessional dynamics in Australian health and social welfare' in Leathard A. (ed.) *Interprofessional Collaboration. From Policy to Practice in Health and Social Care*. Hove: Brunner-Routledge.

Iley K. (2004). 'Occupational Changes in Nursing: the Situation of Enrolled Nurses'. *Journal of Advanced Nursing*, 45 (4), 360-370.

Illich I. (1977). *Disabling Professions*. London: Marion Boyars.

Irvine D. (1999). 'The performance of doctors: the new professionalism'. *The Lancet*, 353, 1174-77.

Irvine D. (2001). 'Doctors in the UK: their new professionalism and its regulatory framework'. *The Lancet*, 358, 1807-10.

Johns C. (2004). *Becoming a Reflective Practitioner. 2nd Edition*. Oxford: Blackwell.

Jones C. (2002). 'Social Work and Society', in Adams R., Dominelli L. and Payne M. (eds.) *Social Work. Themes, Issues and Critical Debates. Second Edition*. Basingstoke: Palgrave.

Jones S. and Joss R. (1995). 'Models of Professionalism', in Yelloly M. and Henkel M. (eds.) *Learning and Teaching in Social Work. Towards Reflective Practice*. London: Jessica Kingsley.

Katz F. E. (1969). 'Nurses', in Etzioni A. (ed.) *The Semi-Professions and Their Organisation. Teachers, Nurses, Social Workers*. New York: The Free Press.

Kilminster S., Hale C., Lascelles M., Morris P., Roberts T., Stark P., Sowter J. and Thistlewaite J. (2004). 'Learning for real life: patient-focused interprofessional workshops offer added value'. *Medical Education*, 38, 717-726.

Larson M. (1977). *The Rise of Professionalism. A Sociological Analysis*. Los Angeles: University of California Press.

Leathard A. (ed.) (1994). *Going Interprofessional. Working Together for Health and Welfare*. London: Routledge.

Leaviss J. (2000). 'Exploring the Perceived Benefit of an Undergraduate Multiprofessional Educational Intervention'. *Medical Education*, 34, 483-486.

Lingard L., Garwood K., Schryer C.F. and Spafford M.M. (2003). 'A certain art of uncertainty: case presentation and the development of professional identity'. *Social Science and Medicine*, 56, 603-616.

Low H. and Weinstein J. (2000). 'Interprofessional Education', in Pearce R. & Weinstein J. (eds.) *Innovative Education and Training for Care Professionals. A Provider's Guide*, London: Jessica Kingsley.

Loxley A. (1997). *Collaboration in Health and Welfare. Working with Difference*. London: Jessica Kingsley.

Macdonald K. M. (1995). *The Sociology of the Professions*. London: Sage

Mackay L. (1998). 'Will the Idea of Vocation Survive?', in Abbott P. and Meerabeau, L. (eds.) *The Sociology of the Caring Professions (second edition)*. London: UCL Press.

Mandy A., Milton C. and Mandy P. (2004). 'Professional Stereotyping and Interprofessional Education'. *Learning in Health and Social Care*, 3 (3), 154-170.

Manthorpe J., Alaszewski A., Motherby E., Gates B. and Ayer S. (2004). 'Learning disability nursing: a multi-method study of education and practice'. *Learning in Health and Social Care*, 3 (2), 92– 101.

Mathias P. and Thompson T. (1992). 'Interprofessional training- learning disability as a case study'. *Journal of Interprofessional Care*, 6 (3), 231-241.

Mathias P., Prime R. and Thompson T. (1997). 'Preparation for Interprofessional Work: Holism, Integration and the Purpose of Training and Education', in Ovretveit J., Mathias P. and Thompson T. (eds.) *Interprofessional Working for Health and Social Care*, Basingstoke: Macmillan.

McCray J. (2002). *Towards a Conceptual Framework for Interprofessional Practice in the field of Learning Disability.* Doctoral Thesis: University of Southampton.

McCray J. (2003a). 'Interprofessional Practice and Learning Disability Nursing'. *British Journal of Nursing*, 12 (22), 1335-1344.

McCray J. (2003b). 'Leading interprofessional practice: a conceptual framework to support practitioners in the field of learning disability'. *Journal of Nursing Management*, 11, 387-395.

McCray J. and Carter S. (2002). 'A study to determine the qualities of a learning disability practitioner'. *British Journal of Nursing*, 11 (21), 1380-1386.

Meads G. and Ashcroft J. (2005). *The Case for Interprofessional Collaboration in Health and Social Care*. London: Blackwell/CAIPE.

Meerabeau L. (1998). 'Project 2000 and the Nature of Nursing Knowledge', in Abbott P. and Meerabeau L. (eds) *The Sociology of the Caring Professions (second edition)*. London: UCL Press.

Miles M. B. and Huberman A. M. (1994). *Qualitative Data Analysis. An Expanded Sourcebook. 2nd Edition.* London: Sage.

Miller C., Freeman M. and Ross N. (2001). *Interprofessional Practice in Health and Social Care. Challenging the Shared Learning Agenda*. London: Arnold.

Millerson G. (1964). *The Qualifying Associations. A Study in Professionalization.* London: Routledge.

Ohlen J. and Segesten K. (1998). 'The professional identity of the nurse: concept analysis and development'. *Journal of Advanced Nursing*, 28 (4), 720-727.

O'Neill O. (2002). *A Question of Trust. Subject of the Annual Reith Lecture.* Cambridge: Cambridge University Press. Available at www.bbc.co.uk/radio4 /reith2002/lecture1. Last accessed 01/04/2006.

Onyett S., Pillinger T. and Muijen M. (1997). 'Job Satisfaction and Burnout among members of community mental health teams'. *Journal of Mental Health*, 6, 55-66.

Ovretveit J., Mathias P. and Thompson T. (eds.). (1997). *Interprofessional Working for Health and Social Care*. Basingstoke: Macmillan.

Parkin P. (1995). 'Nursing the future: a re-examination of the professionalisation thesis in the light of some recent developments, *Journal of Advanced Nursing*, 21, 561-567.

Payne M. (2002). 'Coordination and Teamwork', in Adams R., Dominelli L. & Payne M. (eds.) *Critical Practice in Social Work*, Basingstoke: Palgrave.

Perry M., Carpenter I., Challis D. and Hope K. (2003). 'Understanding the roles of registered general nurses and care assistants in UK nursing homes'. *Journal of Advanced Nursing*, 42 (5), 497-505.

Punch K. F. (2000). *Developing Effective Research Proposals*. London: Sage.

Quinney A. (2006). *Collaborative Social Work Practice*. Exeter: Learning Matters.

Reeves S. (2001). 'A Systematic Review of the Effects of Interprofessional Education on staff involved in the care of adults with mental health problems'. *Journal of Psychiatric and Mental Health Nursing*, 8, 533-542.

Regan de Bere S. (2003). 'Evaluating the Implications of Complex Interprofessional Education for Improvements in Collaborative Practice: a multidimensional model'. *British Educational Research Journal*, 29 (1), 105-124.

Robson C. (2002). *Real World Research. 2nd Edition.* Oxford: Blackwell.

Rosen R. and Mountford L. (2002). 'Developing and supporting extended nursing roles: the challenges of NHS walk-in centres'. *Journal of Advanced Nursing*, 39 (3), 241-248.

Royal College of Physicians. (2005). *Doctors in Society: medical professionalism in a changing world. Report of a Working Party of the Royal College of Physicians.* London: Royal College of Physicians.

Ruch G. (2005). 'Relationship-based practice and reflective practice: holistic approaches to contemporary child care social work'. *Child and family Social Work*, 10, 111-123.

Russell K. M. and Hymans D. (1999). 'Interprofessional Education for Undergraduate Students'. *Public Health Nursing*, 16 (4), 254-262.

Scott D., Brown A., Lunt I. and Thorne L. (2004). *Professional Doctorates. Integrating Professional and Academic Knowledge*. Maidenhead: Society for Research into Higher Education and Open University Press.

Secretary of State for Social Services. (1988). *Report of the Enquiry into Child Abuse in Cleveland.* London: HMSO.

Silverman D. (2002). *Doing Qualitative Research. A Practical Handbook.* London: Sage.

Sims D. (2002a). *Joint Training in Learning Disability Nursing and Social Work: how far is this the creation of a new profession through education and training?* Assignment submitted for the EdD Programme. Institute of Education, London. (Unpublished).

Sims D. (2002b). *A small research project to pilot a questionnaire about perceptions of professional identity held by students qualifying in learning disability nursing and social work.* Assignment submitted for the EdD Programme. Institute of Education, London. (Unpublished).

South Bank University. (1999). *A Decade of Joint Training. The Experience of Joint Practitioners. Report on a Professional Development Day for Joint Practitioners in Learning Disability Nursing and Social Work, June 1999*. London: South Bank University. Unpublished.

Stanley M. and Manthorpe J. (2004). *The Age of the Enquiry. Learning and Blaming in health and social care*. London: Routledge.

Sully P. (2002). 'Partnerships in Interprofessional Education and Practice: the Development of a Masters Programme in Interprofessional Practice', in Glen S. & Leiba T. (eds.) *Interprofessional Post-qualifying Education for Nurses. Working Together in Health and Social Care*. Basingstoke: Palgrave.

Tabouret-Keller A. (1997). 'Language and Identity', in Coulmas F. (ed.) *The Handbook of Sociolinguistics*. Oxford: Blackwell.

Thackwray B. (1997). *Effective Evaluation of Training and Development in Higher Education.* London: Kogan Page.

Thompson T. (2003). 'Learning Disabilities: Effective Partnership and Teamwork, in Weinstein J., Whittington C. and Leiba T. (eds.) *Collaboration in Social Work Practice*, London: Jessica Kingsley.

Thompson N. (2006). *Anti-discriminatory Practice*. 4th Edition. Basingstoke: Palgrave.

Tschudin V. (1999). *Nurses Matter. Reclaiming our Professional Identity.* Basingstoke: Macmillan.

Tunstall-Pedoe S., Rink E. and Hilton S. (2003). 'Student Attitudes to Undergraduate Interprofessional Education'. *Journal of Interprofessional Care*, 17 (2), 161-172.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1999). *Fitness for Practice*. London: UKCC.

University A. (2003). *Definitive Course Document G. BSc (Hons) in Nursing and Social Work Studies (Learning Disabilities) Branch Programme*. Unpublished.

University of Portsmouth. (1999). *The Development of a New Practitioner to Work in the Field of Learning Disabilities. Report Commissioned by the Learning Disability Focus Group*. Portsmouth: University of Portsmouth.

Wall A. (2003). 'Some ethical issues arising from interprofessional working' in Leathard A. (ed.). *Interprofessional Collaboration. From Policy to Practice in Health and Social Care*. London: Brunner-Routledge.

Walton I. and Brown J. (1989). *The Challenge of Change. Nurse Training and Education in Mental Handicap.* York: University of York, Department of Social Policy and Social Work.

Watkins J. (1999). 'Educating Professionals: the changing role of UK professional associations'. *Journal of Education and Work*, 2 (1), 37-56.

Watson D. and West J. (2006). *Social Work Process and Practice. Approaches, Knowledge and Skills*. Basingstoke: Palgrave.

Webb J., Schirato T. and Danaher G. (2002). *Understanding Bourdieu*. London: Sage.

Webber R. and Taylor J. (2000). *Audit of Dually or Jointly Validated Programmes at Qualifying Level by CCETSW and the ENB*. London: Unpublished.

Weinstein J. (2003). *Sewing the Seams of a Seamless Service: a Review of Developments in Interprofessional Education and Training*. London: CCETSW

Whittington C. (2003a). 'Collaboration and Partnership in Context', in Weinstein J., Whittington C. and Leiba T. (eds.) *Collaboration in Social Work Practice*. London: Jessica Kingsley.

Whittington C. (2003b). 'A Model of Collaboration', in Weinstein J., Whittington C. and Leiba T. (eds.) *Collaboration in Social Work Practice*. London: Jessica Kingsley.

Wilcock P.M. and Headrick L. A. (2000). 'Interprofessional Learning for the Improvement of Health Care: why bother?' *Journal of Interprofessional Care*, 14 (2), 111-117.

Wood D. (2001). 'Inter-professional Education – still more questions than answers'. *Medical Education*. 35, 816-817.

World Health Organisation. (1988). *Learning Together to Work Together for Health. Report of a WHO Study Group on Multiprofessional Education of Health Personnel: the Team Approach*. Geneva: World Health Organisation.

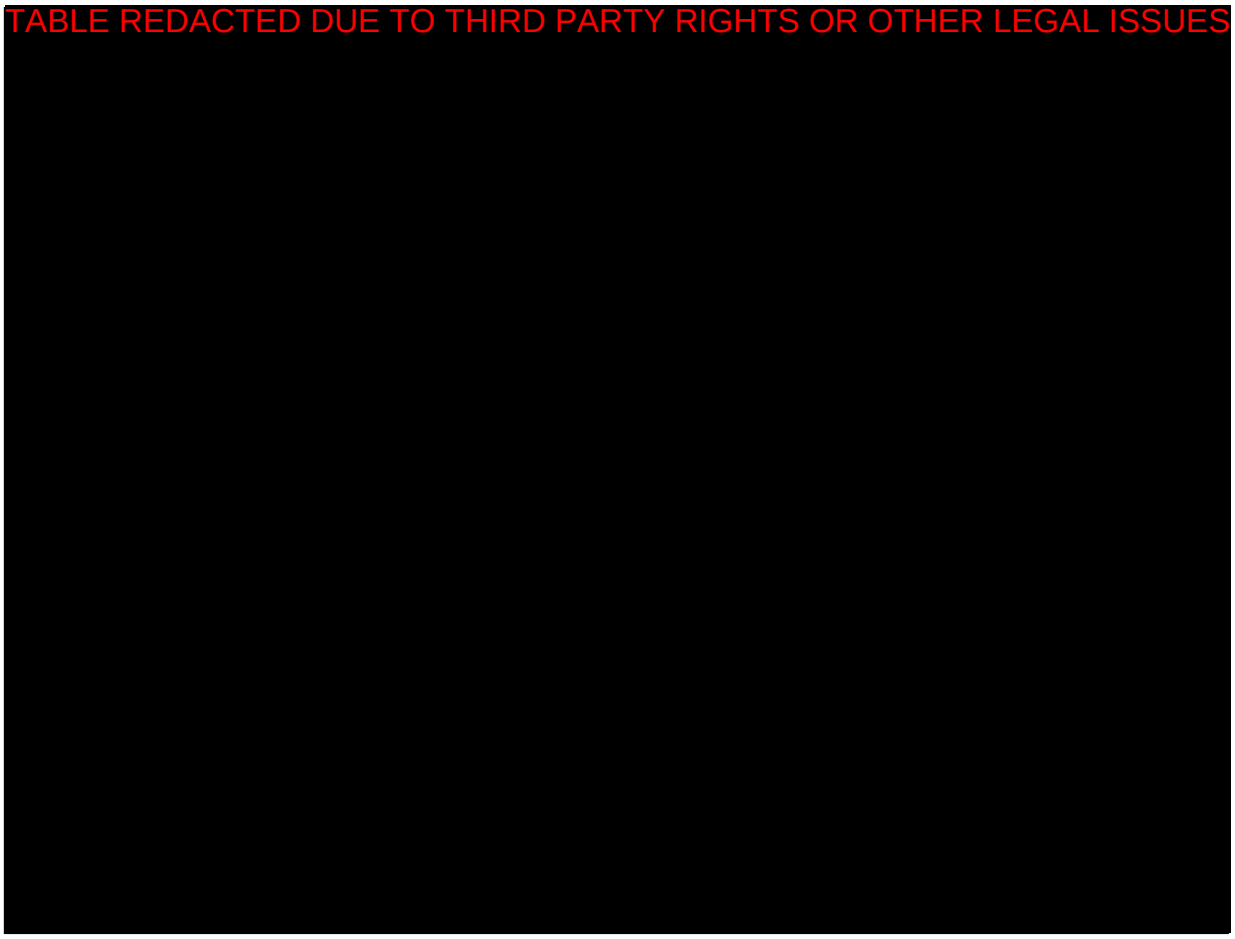
Zwarenstein M., Atkins J., Barr H., Hammick M., Koppel I. and Reeves S. (1999). 'A Sytematic Review of Interprofessional Education'. *Journal of Interprofessional Care*, 13 (4), 417-424.

APPENDICES

APPENDIX ONE

Professional Tensions for Jointly Trained Practitioners

Appendix 1. Professional Tensions for Jointly Trained Practitioners



* Based on characteristics of a profession from Hart, C. 2004. *Nurses and Politics. The Impact of Power and Practice*. Palgrave Macmillan. p7.

Dual Professionalism - a definition

Freidson (1994, p. 10) defines a profession as

'an occupation that controls its own work, organized by a special set of institutions sustained in part by a particular ideology of expertise and service'

and professionalism as

'that ideology and special set of institutions'

Applying these definitions to the case of jointly qualified practitioners, a definition of *dual professionalism* can be offered as: **an ideology of expertise and service which is drawn from two occupations, which are organised by two special sets of institutions.**

APPENDIX TWO

Survey Questionnaire

Survey of Practitioners who jointly qualified in learning disability nursing and social work

1) BACKGROUND INFORMATION

Gender: male/female (delete as appropriate)	
Age	Ethnicity
Please state the year in which you qualified as a jointly trained practitioner	.....
Name of the university/college where you did th joint training programme:	.....
Did you qualify with a Diploma in Higher Education or a degree?	DipHE/Degree (delete as appropriate)
Qualification you obtained	a) CSS/RNMH b) DipSW/RNLD c) Other.....

a) Why did you choose to do a joint training programme? (please comment)

b) What do you remember most about your joint training programme? (please comment)

2) EXPERIENCES OF EMPLOYMENT SINCE QUALIFYING

Current job title:	
Are you working as (please tick):	a) a nurse b) a social worker c) other (please state)……..
Are you employed in (please tick):	a) a Social Services Department b) the NHS c) the independent/voluntary sector d) other (please state)……
Nature of your work (please include which main **client group** you work with):	
Are you currently registered as a nurse (please tick)?	Yes / No
Are you registered as a social worker (please indicate)?	a) Yes b) No c) About to register
When the post you hold now was advertised did the advert include **joint training** as one of the entry qualifications?	Yes/No
Are you employed in a joint team (eg community learning disability team?):	Yes / No (if yes please name the team……
Please identify any previous employers since jointly qualifying (please indicate whether Social Services, the NHS or independent sector):	Employers:
Number of years you have worked <u>with people with learning disabilities</u> since you qualified?	
Have you worked with other client groups since qualifying?	Yes/No (Please tick) If yes, please state which client group and number of years

2a) Do you think that being jointly trained was an advantage when you applied for your current post ? (please comment)

3) SKILLS AND KNOWLEDGE YOU USE IN YOUR WORK

From the following areas of skills/knowledge, please tick the 10 which you use most in your current job:

Self management skills
Self awareness
Using values and anti-discriminatory practice
Communication skills
Presentation skills
Teamworking
Therapeutic skills
Counselling skills
Empathy
Knowledge of health promotion
Conducting nursing assessments
Carrying out nursing interventions
Writing a care plan
Evidence based practice
Evaluation
Risk assessment
Risk management
Inter-professional working
Partnership working
Networking
Advocacy
Leading/supervising others
Numeracy skills
Report writing
IT skills
Teaching others
Planning/evaluating your own development
Reflection
Empowering, promoting, enabling
Conducting social work assessments
Carrying out social work interventions
Providing information and advice
Providing opportunities for learning and development
Working in accordance with statutory and legal requirements
Managing packages of care
Supporting people through change
Planning, monitoring and control of resources
Using supervision
Decision making

4) BEING JOINTLY QUALIFIED

To what extent do you agree/disagree with the following statements (please circle or tick as appropriate).

Joint training prepared me well for dealing with health issues and learning disability

Strongly agree Agree Neither agree/disagree Disagree Strongly disagree

Joint training prepared me well for dealing with social issues and learning disability

Strongly agree Agree Neither agree/disagree Disagree Strongly disagree

Joint training prepared me well for inter-professional working

Strongly agree Agree Neither agree/disagree Disagree Strongly disagree

Joint training has given me an advantage over traditionally trained practitioners

Strongly agree Agree Neither agree/disagree Disagree Strongly disagree

Joint training disadvantaged me because there were gaps in my knowledge

Strongly agree Agree Neither agree/disagree Disagree Strongly disagree

I have used all of the skills I learned in my joint training

Strongly agree Agree Neither agree/disagree Disagree Strongly disagree

I have lost some of my nursing skills

Strongly agree Agree Neither agree/disagree Disagree Strongly disagree

I have lost some of my social work skills

Strongly agree Agree Neither agree/disagree Disagree Strongly disagree

Looking back, I wish I had done a single training course

Strongly agree Agree Neither agree/disagree Disagree Strongly disagree

5) YOUR PROFESSIONAL IDENTITY

How would you describe your professional identity? a) nurse b) social worker c) joint practitioner d) uncertain e) other.....?

(please tick/indicate)

6) BENEFITS AND DISADVANTAGES OF BEING JOINTLY TRAINED

a) Please list up three benefits that you have experienced

b) List up to three disadvantages you have experienced

c) Have service users benefited from the fact that you were jointly trained? If so, in what ways?

d) What have been the main challenges for you in being a jointly trained practitioner?

e) In what ways do you think being jointly trained has made you more effective as a practitioner than had you been singly trained (please comment)?

7) ANY FURTHER COMMENTS? (please add other comments here if you wish)

FURTHER PARTICIPATION

(please ignore this section if you are not willing to be interviewed)

As a part of this research it is planned to carry out interviews to explore the perceptions of joint practitioners in more depth. Would you be prepared to participate? If so, please indicate this by writing your name and contact details/ phone number/email address here:

.....
.....
.....
.....
.....
.....

Thank you for completing this questionnaire.

Please return it in the envelope provided to: Department for Health Research and Evaluation, University of Greenwich, Avery Hill Road, Eltham SE9 2PQ.

APPENDIX THREE

Interview Schedule

DEFINITIVE INTERVIEW SCHEDULE – JOINT TRAINING IN LEARNING DISABILITY NURSING AND SOCIAL WORK

Thank you for agreeing to take part in this follow up interview to the previous survey. Can I first of all confirm that you will remain completely anonymous and no records of the interview will be kept with your name on them. Thank you for also agreeing to allow me to tape the interview – could you sign this statement I shall give you to confirm that?

1. BACKGROUND INFORMATION QUESTIONS

Initial questions about work context

When did you jointly qualify?
From which University?
What is your current post?
Are you employed as a nurse, social worker, other?
Who is your employer?
How long have you been in this post?

Looking back, what do you remember most about joint training?

Prompt questions:

What were your thoughts about the training as you entered your first job?
You were trained to be a joint practitioner. How did you perceive your professional role by the end of the training?
How would you evaluate the impact joint training has had on your practice?

2. WORK SINCE QUALIFYING

There would have been a number of career paths you could have followed. Why did you take the path you did?

Prompt questions

Why did you choose this/your previous posts?

Did you feel ready and able to go for a job in either discipline?
Why? Why not?

3. USING THE SKILLS

Can you think of a situation in your work where you have been able to use both your nursing *and* your social work skills? Can you tell me about it?

Prompt questions:

How did you use the social work/nursing skills in this situation?

Why was this helpful?

Have their been situations in work where you have wanted to use both sets of skills but been unable to? Can you think of an example of this?

Why weren't you able to use both sets of skills?

So, overall, which skills and knowledge do think you most use in your job – nursing or social work? Why?

4. PROFESSIONAL ROLE / IDENTITY

Which profession do you most identify with? Why?

Prompt questions:

When people ask what job you do what do you say?
Do you ever refer to yourself as a joint practitioner? Why?
Do you ever feel confused about your role or professional identity? Why?
Are you currently registered with the GSCC, NMC or both? Why?
Do you work with any other joint practitioners?
What has been the response of other people/singly trained practitioners to the fact that you are jointly trained?
Why do people respond in this way?
Do you think other professionals expect more of you or less?
Do colleagues ever ask your advice because you are jointly trained?
Have there been any conflicts or difficulties for you in being jointly trained?

Do you think your approach to practice is in any way different to that of someone

who is singly trained? If so, what might be the differences?

5. INTERPROFESSIONAL WORKING

In the survey, many respondents felt that the training had prepared them well for inter-professional working. Was this the case for you?

If so, can you think of a situation you have encountered where having been jointly trained has helped you in terms of *multidisciplinary working*?

Prompt questions:

Why did joint training help you in this situation? How?
What was it in the training that helped prepare you for working with other professionals? What skills and knowledge did you learn?

6. KEEPING UP TO DATE

One issue which some survey respondents identified was the difficulty in keeping up to date with both their nursing and social work skills when only practising in one area. Has this been an issue for you?

Prompt questions:

Why has it been an issue?

Are there skills you feel you have lost or used very little – if so, which?

7. EFFECTIVENESS IN PRACTICE

Many of the survey respondents felt that Joint Training had given them an advantage over those who were singly trained. Do you feel this and if so what advantages are there?

Prompts:

Why are these advantages?
Do you feel that service users benefit from the fact that you are jointly trained? If so, how, why?
Have the organisations you have worked for benefited? If so, in what ways?
What have been the disadvantages of being jointly trained?

8. FINAL QUESTION

Are there any other things you want to say about this topic that I haven't asked about or you haven't had the opportunity to say?

Thank you for taking part in this interview

APPENDIX FOUR

Interview Data Analysis – Initial Categories Grid

Appendix 4. Interview Data Analysis – Initial Categories Grid

Respondent:	
STARTING OUT	
BEING HOLISTIC	
USE OF ALTERNATE DISCIPLINE	
CONFIDENCE	
ACCOUNTABILITY	
CULTURAL COMPETENCE	
PLACEMENT INFLUENCES	
ASSERTIVE POSITIONING	
DIRECT WORK	
BOUNDARY TALK	
INFLUENCING	
EMERGING RECOGNITION	
ENCOUNTERS	
VALUES/CLIENT APPROACHES	

APPENDIX FIVE

Letter Accompanying Survey Questionnaire

Appendix 5. Letter Accompanying Survey Questionnaire

July 2005

Dear Colleague

Research about Joint Training in Learning Disability Nursing and Social Work

I am writing to ask if you would kindly complete the attached survey questionnaire. The survey is a part of a national research study which aims to explore the experiences of jointly trained practitioners who have completed a joint programme in learning disability nursing and social work. I am undertaking the research as a part of a Doctorate in Education programme at the Institute of Education, London. This letter was forwarded to you through the university/college where you undertook your training.

As you know, joint training has made a significant contribution to the professional development of staff who work in learning disability services. There has been, however, very little research carried out with professionals who jointly qualified to ascertain their views and experiences. This research therefore represents an opportunity to expand knowledge about the benefits and challenges of joint training and the relevance of that training to practice.

It is important to point out that this survey is confidential and that the information you provide will be anonymous. In the final research thesis resulting from this study no individual will be identified or particular comments attributed to them. The survey is the first stage of the research. The second stage will involve interviews and it is hoped that some people returning the questionnaires will be prepared to take part in these. There is therefore an opportunity to give your contact details should you be prepared to be interviewed as a part of the study.

I would be grateful if you could complete the questionnaire and return it to the Research Centre in the School of Health and Social Care at Greenwich University in the pre-paid envelope provided, by 31st August 2005.

Thanking you in anticipation of your participation.

Yours sincerely

Dave Sims

School of Health and Social Care
University of Greenwich
020 8331 9445
d.sims@gre.ac.uk

APPENDIX SIX

Characteristics of the Survey Sample

Appendix 6. Characteristics of the Survey Sample

Table 1. Gender

Number of male respondents	14
Number of female respondents	33

Table 2. Age of respondents

Respondents aged between:	Number
21-30 years	16
31-40 years	21
41-50 years	10
51-60 years	0

Table 3. Ethnicity of respondents

Ethnicity	Number of respondents
African	3
Black African	2
Asian	2
Irish	1
White British	35
Not given	4

Table 4. Year of Qualification

Year of Qualification	Number of respondents qualifying
1994	1
1996	2
1997	2
1998	2
1999	1
2000	1
2001	2
2002	5
2003	16
2004	15

Table 5. Academic Qualification achieved

Type of Qualification	Number of students achieving it
Degree	21
Diploma in Higher Education	26

Table 6. Professional Qualification obtained

Professional Qualification	Number of students awarded it
CSS/RNMH	2
DipSW/RNLD	45

Table 7. Current Employment

Nature of current Employment	Number of respondents
Nurse	17
Social Worker	25
Other	5

Table 8. Employment sector where employed

Sector of Employment	Number of respondents
Social Services Department	23
The NHS	19
The independent/voluntary sector	4
Other	1

Table 9. Professional Registration

Profession	Number of respondents registered
Nursing	44
Social Work	26
Social Work – about to register	13

Table 10. Joint Training stated as entry requirement for current post

Joint Training listed in the job advert	Number of respondents
Yes	4
No	43

APPENDIX SEVEN

Information regarding Interview Respondents

Appendix 7. Information regarding the 25 interview respondents

(Interviews were carried out between September and December 2005)

Respondent	Gender	Employment	Employer	University/ College	Qualifying Year
Int 01	f	Social worker	SSD	A	1998
Int 02	m	Social worker	SSD	A	2004
Int 03	f	Social worker	SSD	A	2002
Int 04	f	Nurse mgr	NHS	A	1997
Int 05	m	Care manager	PCT/SSD	A	2003
Int 06	f	Social worker	SSD	A	2003
Int 07	m	Care manager	SSD	E	1994
Int 08	m	Nurse	NHS	A	1999
Int 09	f	Care manager	SSD	A	2003
Int 10	f	Training mgr	Independent sector	A	1998
Int 11	m	Nurse	NHS	A	2004
Int 12	m	Social worker	SSD	A	1998
Int 13	f	Training mgr	Independent sector	B	2003
Int 14	f	CAMH primary mental health worker	Mental Health Care Trust	C	2004
Int 15	m	CAMH practitioner	NHS	B	2003
Int 16	m	Nurse	Care Trust	A	1997
Int 17	f	Social worker	SSD	C	2004
Int 18	f	0.4 nurse LD 0.6 project leader	NHS/ Independent sector	C	2004
Int 19	f	Social worker	SSD	B	2004
Int 20	f	Social worker + bank nurse	SSD/NHS	B	2003
Int 21	f	Nurse	NHS	D	2002
Int 22	f	Social worker	SSD	B	2003
Int 23	m	Nurse mgr	PCT	A	1995
Int 24	m	Nurse	Care Trust	A	2003
Int 25	m	Nurse	NHS	A	2000

APPENDIX EIGHT

Case Summary – Interview Extract

Extract from interview with respondent Int 23

Respondent: *I was working with a young woman who was diagnosed as having epilepsy that couldn't be managed and she was on a huge range of anti-convulsants and was regularly fitting and getting herself into quite difficult situations really. She lived at home with her mum and abusive older brother and had a history of abuse within the family. I worked very closely with her. Originally she was referred around her medication and managing her medication and trying to control the epilepsy, and through working with her quite closely around that we gradually, through monitoring and all the rest of it, started to realise that the majority of the seizures were in situations where she was feeling quite anxious. It turned out that they were anxiety attacks rather than epilepsy and the medication she was on was not required or helping her in any way and if anything it was making her more vulnerable. So by reducing the medication, increasing her confidence and self esteem we managed to support her to move into a Housing Association flat on her own, with some support. So there was a lot of sort of social work activity around working with the Housing Association, looking at packages of support and the Benefits associated with that, and then supporting her around keeping herself safe, avoiding abusive situations and managing emotional relationships with her family and all of that. And to the best of my knowledge she is still in her flat with very very few seizures, in inverted commas, and on hardly any medication now.*

I felt that that was a situation that used my whole range of skills and it wouldn't have worked successfully if this was a case of.....right, well I will do this bit with your medication and then you need to go and see someone about yourself esteem and then you continue to.....because she just wouldn't have trusted anybody enough or been able to manage that sort of complexity really... I brought the social worker in rather than passing it on.'

Interviewer: *This seems like a good example of where a client could fall between two professionals?*

Respondent: *Yes, and had done over the years. Her social situation was seen as resulting from her health situation and do you know what I mean.....I mean 'you need to sort her epilepsy out, we can't do anything until her epilepsy is under control'.....and her epilepsy would never be under control until her social situation was addressed.* (Int 23)

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